MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Thursday, September 17, 1998

The meeting in the above-entitled matter convened, pursuant to notice at 11:23 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

DONALD THEODORE LEWERS, M.D.

HUGH W. LONG, Ph.D.

WILLIAM A. MacBAIN

WOODROW A. MYERS, M.D.

JANET G. NEWPORT

ALICE ROSENBLATT

JOHN W. ROWE, M.D.

GERALD M. SHEA

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P R O C E E D I N G S [11:23 a.m.]

DR. WILENSKY: As many of you know, we frequently try to use the September, and occasionally October, meeting as well to get into issues that may not be directly focused on a specific chapter at hand but which either follow on issues that we have raised in previous years' reports or continued discussions that we believe we will have as part of our future reports and bring in outside experts to help us deal with some of these issues. We are going to be doing much of that the rest of today in terms of focusing on several areas with regard to quality assessment work that is going on in the government and outside the government.

But this morning we're going to continue what was the beginnings of a discussion that was raised for, I believe the first time exclusively in our report last year, which is on the care of the terminally ill and dying. And we are very pleased that two of the people who are most expert in this area have agreed to present to the commissioners and to talk about work that they're doing, and in particular a demonstration model that they have just started, Joanne Lynn and Anne Wilkinson are here from the

Center to Improve Care of the Dying from George Washington University.

A number of you, I know, know one or both of them. I have heard them speak in other forums and we're really pleased that you've been willing to come and address the commissioners. We turn it over to you.

DR. WILKINSON: Thank you and we're happy to be here.

DR. LYNN: Thank you very much. I'm going to launch pretty directly into this. We're building obviously upon the claim that I think Jack Rowe made at one of your meetings that the dying in America is a national disgrace. It certainly is once you focus upon this, but it's astonishing just how blind we have been as a culture to what is happening at the end of life. Part of that is because it's new.

It's really only about 50 or 60 years ago that the average age at death was still in the forties. Most people died suddenly, even of diseases we now think of as chronic illness, people then died suddenly. So until sometime in this century people died of diabetes within a month or two.

People died of cancer within a month or two.

Heart disease usually killed you the first time you knew you had it, and if you managed to survive for a little while, it was terribly disabling and then you died suddenly within a few months. There was very little long term chronic disability. People died of infections, childbirth, accidents and at almost every decade of life and you had a little more chance of dying in the first decade, but after that you had an almost equal chance of dying in every decade.

So one would imagine that life would have felt very differently at a time when people who went away for a few months really had some real chance of not returning. And goodbyes would have sounded differently and so would our health care system. So when we debated Medicare in 1965, if you look at the cases presented, the cases presented were almost all of the surgical variety. The farmer who can't get his hernia repaired and, therefore, can't farm and he's 68-years-old and he can't ever get the money ahead to get his surgery done.

I'm here to tell you that if that's the problem

that Medicare was meant to solve, Medicare solved it. There are no farmers still awaiting hernia repair at 68. But what we've done is changed the demographics so that most people now face dying with one or another serious long term degenerative illness. We see it, of course, as a problem. I see it as a tremendous opportunity. I wouldn't go back to the disease array we had in 1900. No way.

The chance to grow old and die slow is a wonderful chance. It's one of the grand accomplishments of our culture. But we need to have changed the care system to match because now we have most women having five or six years of disability ahead of death; most men, three or four. 80 percent of those of us who die in Medicare have one of only five diagnoses in the year before death; cancer, stroke, heart disease, COPD and CHF, obstructive lung disease and heart failure. So there's -- I'm sorry, dementia. Dementia -- I said heart disease.

So 80 percent of us are dying with one combination or another of those. There's been much made of how much we're spending on end of life care but until you multiply things out, you don't realize just how big it is. We're

spending more than 10 percent of Medicare in the last month of life. We're probably spending on the order of half of Medicare on the disease that kills you.

It's hard to see because no one has ever actually done that analysis but it looks like a pretty easy claim to me that you would be spending more than half of Medicare on the disease that eventually causes death. You're living with it a long time, but early on you could predict this is going to be the cause of death unless the person gets something even worse along the way. So the category has changed.

If you look at the graphs in the hand-out that we sent you, on page seven we can show you a little bit of why that's changed. The American cultural conception of what it is to be dying is essentially to have a neon sign on your forehead saying, I'm not here long, say goodbye, you won't have long. If you ask hospice professionals, or you ask doctors, you certainly ask ordinary citizens what do people look like on the day before they die and they call up an image of people who are in bed, they've lost a lot of weight, they're terribly, terribly sick, they may be going

in and out of consciousness.

If you say, well, what does a person look like dying of lung cancer, they'll even escalate that. It's perfectly obvious they aren't going to live very long. Say how do they look a week ahead, they'll say it looks really pretty obvious this person isn't going to live for a month, they might make it a few days but they aren't going to make it a month.

It turns out when you actually do the data, which is the bottom graph on your page seven, that 20 percent of the median estimated survival on the day before death of lung cancer there's a 20 percent chance to live two months. That's true if you ask doctors and it's true if you ask a statistical model. When you show this to people who even work in the field, they say your data has got to be wrong. That's not the way people look before they die of lung cancer.

So you say, okay, so tell me your last few cases who died of lung cancer and see if we're really off base. And they start remembering, oh, yeah, there was that guy who hemorrhaged, or there was that guy who seized, or that guy

who got a bad fever and we knew he had bad lung cancer so we didn't go after it and he died in just 24 hours. Yeah, the day ahead I would have given him some chance of making it. You start adding up, oh, yeah, there's this group and it turns out to be a quarter or a third of lung cancer patients have unpredictable dying.

The ones we remember are the ones who stereotype it, who follow the absolutely projected course. That's bad enough until you look at the other disease. Look what happens to congestive heart failure. The day before death the average person still had a 65 percent chance to live two months and a week ahead an 80 percent chance to live two months. If you go to six months, those figures are not very much different in congestive heart failure.

Why is that? If you look at the top graph on that page, this is stereotyped a little but it was actually in your report from last June so you've seen this before. Colon cancer, and other solid tumor cancers mostly cruise along kind of doing okay until about two months ahead of death when people start really losing weight, losing function, getting sick, and they really aren't terribly

disabled until that last couple of months.

That's when the public and their family and everybody else can recognize that they're failing now. If you look at a disease like dementia, congestive heart failure, it's much more long term disability with occasional terrible episodes. Most of the time you're rescued from the terrible episodes and then along comes one where you didn't get a rescue.

That's a very much more difficult way to anticipate the dying. These people don't ever get told they're dying because they don't have the culturally expected last dwindle, the failing phase, they just suddenly up and die in the context of their disease.

If we're going to serve the last phase of life, we have to develop a care system that knows how to take care of that kind of dying also. That we don't really have in place. We have a set of behaviors in place for the cancer trajectory. Once a person starts really losing weight and taking to bed, they're supposed to say their goodbyes and make peace with God and give away their possessions and die on time.

It's one of the terrible things to have done all those things and then survive, but we don't have a socially accepted set of behaviors for the congestive heart failure patient. Nor do we have a care system that knows how to make sense of this. So that in our study, lung cancer patients had an 8 percent or 9 percent chance of having an effort at resuscitation.

CHF patients had a 30 percent chance. No one thought they were going to succeed with these patients, these are terrible hearts but no one ever got around to having the conversations to put in place an order against resuscitation because there never was the trigger.

So anyway, dying as a category has changed. We have to really think through how we're going to arrange things for this serious chronic illness that ends in death as a major contributor to the health care scene. It costs a lot. Most dying is in very few illnesses. Most probably in a very few trajectories.

Interestingly, one of the major trajectories doesn't even have any data, and that is the person with multiple organ system failure on the basis of old age.

The 88 or 90-year-old who has what's called homeostenosis, that is all of the organ systems have very little reserve, then they get hit with some ordinary threat, a cold, and it's too much. That trajectory of dying we don't even collect data on. We insist that people have a textbook disease to go onto the death certificate.

There are some promising directions for thinking about change. If you turn to the graphs on page nine, a couple of the ideas, just sort of graphically that we've been working with, one is that we've organized illness by disease categories. We organize it the way medical textbooks organize disease. There's a chapter on diabetes and there's a chapter on heart failure and so forth. And we think it through as to how we're going to take care of diabetes.

Very different things happen if you think about taking all the diseases in their end stage and saying early in the disease it really makes sense to have somebody who is really hot stuff in taking care of heart disease or really terrific in managing diabetes, or whatever it is that's your problem.

But as you get to the point where you're quite disabled or it's clear you're going to die of the illness, a very different set of priorities come to the fore. People are not looking so much for rescue, although they'd still like to live longer, but they're looking for symptom management, family support, protection against bankruptcy, reliability, the sense that here is a care system that knows what it's doing. At that point things like continuity in symptom management become terribly important and important across illnesses.

So there seems to be a convergence of the kinds of things that are priorities. Also if you look at sort of who are high cost utilizers, at least half of the tail -- our graph here is not one of our best, because it's probably not all of the tail, it's probably half of the tail of high cost utilizers are completely predictable at the beginning of the year. They already have the disease that's going to run up big costs.

Their only big impact is when they're going to die. At that point, their expenses stop. But if you have a substantial population you can predict how many of them are

going to live for how long, therefore, how much the expense is.

This is a population that's extraordinarily easy right now to select against in managed care or to select for in fee-for-services, they pay a lot of bills. They're easy to spot, they've already got the disease. It doesn't take a doctor to figure it out; you know, a simple quiz. You've been in the hospital recently and for what gets you almost all the information you need. If we could figure out how to serve and price services for that population, a really interesting thing happens to the rest of the pool. It becomes an appropriate risk pool because most of the rest of the high cost utilizers are not predictable.

So if we could figure out a way to appropriately risk adjust for this population, we'd have some very nice effects upon the rest. And if you pick up the Yellow Pages in any city in the country and you leaf through looking for who takes good care of really sick people, you will find three ads for hospice programs and nothing else. No nursing home says we do a really good job with end of life care, no hospital says it, no doctor says it. Why is that? Because

no one is making money on it.

If you had a fair price for this population, we could have competition on value and price. That it seems would be a salutary thing for those of us who all, after all face getting old and dying. So it seems like people have to be able to make a living at doing a good job here and not just at gaming the system, which is how you make a good living now.

If as one of the programs we're working with in congestive heart failure can take the average per patient cost from about $250 a day down to $50 a day, while increasing value, if you could generalize that practice, that would be terrific. The only problem is at $50 a day you still have a loss leader in managed care. At $50 a day, that's $1,500 a month, nobody gets paid that.

So you still do not want a reputation for doing a wonderful job, even if you have the best program in the country. That it seems is a serious problem for really making a reliable system for all of us. There's almost no reliable research. The National Health Policy Forum held a meeting on this last year. They were able to generate 12

data-driven studies relevant to end of life care. It is astonishing how little we have focused on this, how little we built databases that make any sense of it.

We don't have databases that combine clinical information on severity with expenditure information. Even the most simple of studies; you all relied, for example, on some studies on whether hospices save money. Those are terribly flawed studies. You would not want to rely on them if you looked at them closely.

So the few that are out there are also very frail, even the work that James Lubitz has done, which is terrific work, he'd say has no clinical information. It's just counting backwards from death and seeing how much you spent. You can't separate the people who are predictable from not out of billing data. So you almost can't fail in launching into this arena.

It must be the feeling people had when they first hit the Great Plains. Anything you plant will grow because nothing has been planted there before. So we did a little brainstorming on just the kinds of things that could readily be done on existing databases with not huge amounts of money

and these are the kinds of things that we suggested.

Investigate patterns of utilization. How do people come to the end of life? What do they actually end up spending? From the time in which it's clear they've got a bad disease, what happens to them? How many get bounced from one doctor to another? How many get continuity? Does continuity make a difference?

In areas in which only 20 percent of people die in hospitals and areas in which 60 percent of people die in hospitals, is there any difference in the quality of care? Is there any real difference in the cost, especially if you start accounting for costs outside of Medicare? Is this really just a displacement phenomenon where Medicaid and family are picking up a lot of costs?

Variation by disease is going to be a big one. Variation by age, the data that Lubitz and the data that we put together seem to show that there's an enormous drop off in Medicare based cost at around age 80. Is that real? Is it good? Is it something that society would like to keep going or is it an age bias that really ought to be undone?

That really needs some investigation. There are

some areas which seem to be just on their face obviously inadequate care. Patients who just get bounced from pillar to post, go from one doc in the box to the next; get a different doctor every time they show up at the hospital and yet have an ongoing disease are guaranteed never to have been able to have a promise made or guaranteed never to have been able to have an advanced directive discussed.

It seems like per se inadequate care. How commonplace is it? Does it have an effect upon utilization? You at least could check utilization, you might even be able to check satisfaction and some other outcomes but at the very least, even utilization. Does it make a difference if chronically ill patients don't have a continuity physician or do? And that it seems we could do.

There is at least one classic, archaic drug being used in large quantities. It is meperidine, it's a kind of opiate. It's probably outdated shortly after the time of my birth. Nevertheless, I am told there are places in the country in which it is the dominant prescription drug for chronic pain. It would seem very easy to use DEA records and identify the areas of the country where it's being used

and focus in on that. It seems like a serious quality problem that the data already exists.

Nursing home, what I call dumping. People being put into nursing homes with no advanced care plan, no strategy for how they're to be cared for and going on to be treated or die with no coordination between the nursing home and the hospital center. Happens enormously in some states, virtually never in others.

Substantial small area variation depending to some extent upon Medicaid nursing home regulations and enforcement practices in which in some states if you kept a sick patient in the nursing home, at least a few years ago, you were at risk of serious penalty so the strategy was to put people back into the hospital.

My guess is that that strategy is going to go up as the bundled payments go into place for SNFs because one way SNFs can dodge high cost patients is to remove them to the nursing home. High reimbursement patients are all rehab patients. These are not rehab patients. So they're at real high risk it seems of being moved back to a hospital as soon as they require expensive treatment.

To go on a little, exploring how to monitor improvements, some of the people you're having later today should be asked how you're going to know if you get good care at the end of life? It should be a big issue in Medicare.

Not a single thing in HEDIS; not a single thing in FACCT right now measures end of life care. JCAHO at least measures whether you have a paying program and whether you have a process in place for advanced directives. That's it. There is no consumer information in the Medicare consumer information endeavor. The big endeavor that was just put in place in the last year has nothing on end of life care.

It would seem that if you knew that most of your total expenditures were going to be on your fatal illness, the one of the things people would want to have selected care providers on is whether they know what they're doing with serious illness and yet we have no way of checking whether hospital A or hospital B or health plan A or B is doing a better job.

The Balanced Budget Act is going to have big impacts on this population. We need to ask people HCFA and

other places what's going to be the impact? They say, oh, we hadn't thought of that. The questions have not been raised or asked.

Hospice effects I've already mentioned.

The effects of high cost palliative care are a new threat to our field. Twenty years ago when I started in hospice care you couldn't run up a big bill. It didn't matter what you did, you couldn't run up a big bill. Now gemsidabine being alone, a chemotherapy drug that clearly reduces symptoms, costs $100 a day to administer. That's equivalent to the cost of hospice care. So if you allow hospice patients to have gemsidabine, you have completely used your Medicare allotment for that patient. Everything else is a loss leader, so the ordinary care becomes an add-on.

Totally implantable electric defibrillators. The cardiologists believe they can save 20,000 people by implanting them in 100,000 people next year. Their first two year costs are $100,000, multiply it out. That's $10 billion in electrical defibrillators in the next two years. If they're right in their projections, and my guess is that

as soon as those things are out there being used widely, they're going to be put in nursing home patients. It's not going to be 100,000 people. It's going to be many more.

Are we really ready to spend that much Medicare money on something that makes sure that your end of life course with cardiac disease is miserable? It does extend life, but you no longer die of a sudden death in arrhythmia, you now die of cardiac concexia or being stopped on a ventilator. Most people would choose against that but there's no pattern of making sure that people have that choice.

Anyway, there's more on here but I get the sense that I should probably encourage you to jump in at this point.

Let me just close by saying that it seems that we have to have the same kind of revolution we had with the care of women facing pregnancy and delivery. In 1970 women were routinely terrified of what the care system delivered and there was a substantial revolution over the following 10 years in which now the usual woman coming to the usual OB care no longer feels that the biggest threat is the care

system. They feel some reason to be confident of the care system.

We need the same kind of thing in Medicare where people can say, look, I'd rather live forever but if I have to have an awful disease, I'm glad I've got a care system that knows what it's doing; I can be confident I'll be comfortable, well cared for in a system that can value high value care. I think if we focus on that for the next 10 years or so before all the boomers hit, we can have a system that will look dramatically different than it does today. I think we haven't even begun to think of how dramatically different it could look but it will be one that all of us can count on when we need it.

DR. CURRERI: I really enjoyed your presentation. There was one thing that confused me in your handout and maybe you could expand on it a little bit. I think you were very convincing, or it is very convincing that these chronic diseases are not very predictable in terms of when you're going to die. Then at the end of your chapter you suggest 18 demonstration sites to take care of these people in the end stage.

I wondered how you're going to do that if it's so unpredictable of when they're in their end stage and whether, for instance, in your figure four, you might want to amplify how you identify these people in the circle which is the people I guess you would be focusing on because you didn't really address that in the handout.

DR. LYNN: It's really a mind shift from thinking about a reliable prognosis. The whole hospice program incidentally is run on a prognosis, it's never been defined. Is the just barely qualified person 49 percent likely to live six months or 1 percent likely to live six months; a 10,000 fold difference in the size of a population depending on which definition you think you have.

So we've been running with this utter ambiguity even in the hospice program. But if instead of thinking about it in terms of a precisely definable time frame you thought about what people need, and once you're this sick, whatever the this sick is, we'll have to define that, then probably you have pretty consistent needs with all other people this sick.

And the care system ought to take care of you even

if knowing that 10 percent are going to die this month and 10 percent are still going to be alive in three years, that an uncertain prognosis is not a reason to turn our back on the care need that people who have an inherently unpredictable illness, some are going to make it three years and some aren't going to make it for 10 months or two months.

DR. CURRERI: I guess though what I'm asking you is to tell us what your idea is of this --

DR. LYNN: It turns out in CHF and COPD to possibly be fairly easy, and that's a third of all dying. It may well be that once you've had a round or two of pulmonary edema with congestive heart failure or a round of two of ventilator failure with COPD and some baseline measures to make sure that it wasn't just that you were thrown into it by a bad drug or something, then probably from that point forward you have bad established disease that's overwhelmingly likely to kill you. And it turns out from some data that Chris Hogan ran here that didn't yet make it into any of your reports, that you have almost the same expenditures every year from then on out no matter how

long you live.

It's the people who live one year, spent $22,000 that year; people who live two years spend $22,000 both years. So that it appears that once you're that sick you have pretty continuous care needs at about that level but that's the kind of testing that we actually need.

Where in the course of Alzheimer's would you place the sick enough to be into some sort of special coherent care system? Is it the point at which people are fecally incontinent. Is it the point at which they're mute? Is it the point at which they can no longer walk? Is there some combination of six such elements that you'd put in a score?

I don't know, but I know there's one there that will work and that is probably capable of being articulated in a way that's not too gameable for a public system.

The really nice thing I know with COPD and CHF is that no one puts a person into congestive heart failure just to qualify them for a benefit, so a person who gets into congestive heart failure is really sick and that's not going to be gamed. If that's enough to qualify them for some coherent funding and care system, then it's a non-gameable

threshold.

But there need to be a dozen experiments going on to see what are the expenses from this point forward? What does the survival curve look like and what would be a fair pricing structure which might be a capitation rate, might look very different, might be more of a hospice type of payment where doctors' fees are separate and it's a daily fee for the core program.

I think there's a need for a real firm end of innovation to figure out the authoritative answer to the question, putting confidence there.

DR. MYERS: Thank you very much for your paper and for your insights. I really appreciate it and you've clearly -- the hospice movement has added a lot to the lives of families and to patients but there are a couple of areas that were not mentioned in either your oral remarks or in the paper that perhaps you've done some thinking about and perhaps also deserve some research effort and time by the commission.

The whole question of cultural and ethnic differences with respect to advanced directives, DNR orders,

the desirability of hospice care, the availability of hospice care. Those issues I think in addition to the geographic differences that you did mention, and did reference have an ethnic, racial and other dimensions that I think are quite relevant as well that really deserve a look.

Then I would add to that the question of source of payment outside of Medicare for the areas that Medicare does not cover. Specifically, whether the presence or absence of wraparound coverage, our Medigap policies, the presence or absence of a Medicaid supplement or whether or not that individual is self-funded or not funded for the difference.

I think that that variable might suggest that there are some other differences that you want to look at. I would suggest that the course of congestive heart failure of clinically similar patients in the South Bronx is different than that of the upper eastside. And the availability of the kinds of services that you've discussed are different in those areas as well.

DR. WILKINSON: We would heartily agree. The program that we're presenting is sort of like the first step. The idea of MediCaring is the first easily getting

your hands around disease and there certainly are all of the questions that you've raised but there is no research on that either.

DR. MYERS: I know that Tom Rathman at Stanford and the intensive care unit there, who does a lot of end of life type of thinking and research and the Stanford biomedical ethics folks are at least beginning to address that question and maybe there are others as well, I'm not as familiar with their literature as I'd like to be but it does seem to me that that's an area very much worth considering and thinking about in addition to what you've raised.

DR. WILKINSON: And absolutely in terms of just anecdotal evidence there are differences in choices about medical care and different ethnic populations and all of that needs to be looked at. This is just the beginning and certainly we would agree.

DR. ROWE: I also thank you. We're all aware that Dr. Lynn and her colleagues have made a very important contribution in this area. They've increased awareness and at the same time they've produced clinically based data that informs policy discussions. An area that I think is worth

adding to the list, and these are all related, has to do with training. In my position I sort of see the greatest efficiency is that the physicians on our staff or faculty are not adequately trained with respect to the database.

There is a specific database about how to take care of people at the end of life. It's embarrassing that people are still giving me meperidine or Demerol as its trade name is. I'll have to check to see if that's still on our pharmacy list. I didn't think anybody used that anymore but I'll find out probably we do. But what happens is physicians are not comfortable with this clinical setting, they're ordering tests that are invasive and often painful and not contributory. They are, therefore, providing a role model for their trainees, which is inappropriate.

It's nice to have some Medicare payment policies that influence things but I think this is, in fact, if anything else as much in America a GME question as it is anything. We think of GME and we'll get to the chapter outline sometime tomorrow about are there too many doctors?

And we're thinking of orthopedists versus plastic surgeons versus neurosurgeons versus primary care doctors.

These silo categories of what their credentialing is, I think we have to think across as well as what should all the doctors who are paid by Medicare who are going to take care of Medicare beneficiaries, what should they be armed with?

This is a part of the curriculum of medical education at some level which is grossly missing and I don't know if you have a response to this, and I don't know how we would do this but I'd like to just -- I want to know that my doctor -- I don't care too much I don't think about where it is I die but I want to make sure my doctor has been trained to understand and expect the complications and to deal with them in a cost effective way. I think we can really save Medicare money from that point of view rather than implantable defibrillators.

DR. LYNN: Medicare has the leverage to do that because so much of the payment is through Medicare support of graduate medical education and yet graduate medical education in general has not supported doctors being trained in hospice or home care settings. There's been no requirement that you ever show that you got competent at managing even the opiate doses or anything of that sort,

much less the counseling. So it's a tremendous opportunity.

DR. ROWE: It appears to be an accountability issue that will come up in GME discussion.

DR. WILENSKY: Why don't we hold this? It clearly would take Medicare into a new area, not with regard to this specialty, this aspect but having the payment be tied to specific courses.

DR. LYNN: Of course, you could always do a carrot. You could say that every training program that will put this in place for three years will get even a very small grant or something. The costs will be included for three years or something. Carrots and sticks work.

DR. WILENSKY: No, and that's something we can take up but it was just in general this is not what we have done with regard to GME, we have to specify the components that are in it.

DR. ROWE: I know that and I'm not looking to grow the program. I guess while we've got Dr. Lynn here, and she won't be here during the GME discussion, maybe it's worth getting her comments on whether such a thing has been tried anywhere? Is it effective? Is it valid? Does it cost a

lot?

DR. WILENSKY: If you do know, that would be --

DR. LYNN: Certainly, the fact that more than half of oncologists answered on a survey by the Eastern Cooperative Oncology Group that they did not know how to handle opiates ought to be seen as shocking. That would be like obstetricians not knowing how to tie umbilical cords. It seems that at all sorts of levels the community ought to voice outrage that medicine has managed to avoid such an obvious service to its community.

But whether which specific incentives are needed, I have the sense that the community demand is getting to be big enough that you all saying that you're concerned might stimulate a third of the medical schools in the country. And if there was a little bit of money attached, you could include it in your cost report for three years or something, my guess is that it would have tremendous impact.

This is not an era in which there are lots of people saying no, we ought to keep doing it like we did in 1970. This is an area in which people are saying we've got to learn how to do it better but they do need to be

pushed a little to get there.

MR. MacBAIN: Let me add my appreciation. I think this is an issue we haven't addressed nearly enough. It seems to me, if memory serves, we talked about this a few months ago. We were looking at data that at least gave me the impression that focusing on the cost of dying isn't the issue or the cost of treating people in the last month or the last year of life, what you're really doing when you do that is taking a subset of the larger set of people who are terribly ill, all of whom are expensive, and because you don't know a priori whether, the flag doesn't go up to say now this is the last month of life or this is the last year of life.

It's really not a very useful focus of analysis either for clinical purposes or for prospective reimbursement, for prospective payment and risk adjustment. I think that's what you're saying is that we should focus on some level of seriousness of the disease that is in all probability going to kill you and not worry about whether you're in the last month of life or the last year of life or the last five years of life, that's not the issue.

The issue is that you now have added a new phase of your health standard that requires a different clinical and different financial approach. If I understand you right, I think that really takes us into a much more useful analysis.

DR. LYNN: You said it better than we did.

MS. JACKSON: Thank you, Dr. Lynn. I heard you before at some conference and I always am pleased to hear you speak about some of the things we need to be doing when it comes to dying. Many people are very unrealistic about death. We all know that we are but we don't think about it very often. I, too, think that money should be spent not only for the physician to, I don't mean to educate him to the fact that we're going to die but to help us die.

But individuals should be educated to the process of we are going to die and there are certain things that can be done and there are certain things that cannot be done. Is there a study or program that can be used to educate these people?

DR. LYNN: The education of the community is coming along but I should point out it's anything behind the

education of the professionals. We have almost no public stories, no evening sitcoms that have a sick person who is going to be sick all year. No shared vignettes. Cardinal Bernardin is sort of the most widely known person who died slow and publicly. It's astonishing, we have no myths.

My nursing home patients will say I don't want to die like that girl in New Jersey and they mean Karen Quinlan. Part of me says that's not among your options, that's not what will happen to you but what they're trying to say is they don't like to be hooked up to machinery and have this all dragged out and so on but they have no other story to relate to.

It is astonishing how much we have kept, how we now come to the end of life under wraps. So a piece of it is just telling stories and starting to figure out which ones we like and which ones we don't like and which ones we're willing to pay for and which ones we aren't. There's a lot of effort going into this now. I just saw a show on Homicide the other night that started to deal with the problems of hospice care. It's starting to creep in but I think it would also take some very deliberate education.

It would be wonderful if part of Medicare's education to the consumer included at the very least to tell people what they should ask. Ask your care system is this a system that knows how to follow you if you go in and out of the hospital into home care? Does the doctor ever do home visits? We've written a book called The Handbook for Mortals which will be coming out in a few months. It's for the public. We give some pretty hard hitting advice.

It says for a patient with obstructive lung disease, for example, emphysema, we say before you get sick, you need to ask your doctor if your doctor has ever given sedation to keep a person from suffocating at the end of life and if they're comfortable doing that, and if not, you need to change your doctor now. Don't wait until then because you'll be too sick and you'll end up on a ventilator.

So if that's what you want, you need to be picking your care system on that basis. That isn't out there. It's certainly not out there in anything Medicare says.

The politeness of the way we talk about end of life, it's just astonishing. Go to the American Cancer

Society and ask for a brochure on how you die with cancer and you get a brochure Living With Advanced Illness. Look at the AHCPR guidelines on congestive heart failure, a $1 million project, two-page spread, really nifty advice on how you diagnosis and treat heart failure until you get to the bottom right of the two page spread, then you get more drugs, heart transplant, good outcome, no, more drugs, heart transplant, good outcome. It never goes off the page.

A third of us die of the disease and our national guidelines don't notice it. It's amazing. Think of newspaper headlines. How many times you see a newspaper headline saying new drug promises to save X number of people? Or the totally implantable cardiac defibrillator could save 20,000 people next year. Doesn't save people, changes the disease. It makes them live a little longer and die a different death. Boy, does that sound different in a headline.

So I think we've come from hundreds of years of dying suddenly and having it mostly out of our control.

A study in LaCrosse, Wisconsin published in February showed that of the people dying in multiple zip

codes, it's the only population based study, my metaphor of the verdant fields of the Great Plains is one population based study of how people die in modern America. It's in LaCrosse, Wisconsin. Turned out that nine-tenths of the patients died after a deliberate decision to stop treatment. And yet we talk about decisions to stop treatment as if there's still a little bit of a pause, a little bit of something weird going on, it's mainstream, the other 10 percent got hit by a truck.

So it takes awhile, I think, for our culture to catch up with these changes and we should push it along, I suppose also be tolerant that it's pretty unlikely that we're going to learn -- a woman told me a couple years ago that she'd always turn to the Bible for guidance in times of stress and yet here she was at 86 dying of this illness that was taking her in and out of the hospital all the time and she said there's no one died like me in the Bible.

You know she's right. No one died like her at the time of the Bible. We need new stories. What counts is good dying in the face of what we now get.

Remember, this is the problem we want to have. We

do not want to go back to dying in childbirth of infectious disease. I want to grow old and die slow but then I want a care system that makes sense of that and that understands that it's okay to be uncertain about when you die, to be looking for symptom relief and to be worried about the burden on a family.

We don't have a polite language in which we can talk about how much we bankrupt families. If you go to court over a treatment decision, you aren't even allowed to present information about the degree to which the family is being bankrupted. I mean it's astonishing the degree to which we have to change a thousand little points.

DR. NEWHOUSE: Thanks, Joanne. This is an excellent presentation. This is a tacky question really following Bill Curreri and Bill MacBain, which is you talked about studying the issue and the lack of studies and as Bill said the studies seem to kind of want to identify a population that had reached some homogeneous state.

Now if the staff is going to do that study or somebody in the broader research community, they have to have some kind of database that would identify this

population, and the question is do you know of any?

DR. LYNN: No, I think at this point there are some databases you can work from, the National Mortality Follow Back Study, the Duke Cardiovascular Disease database, there are some big -- the longitudinal study on aging. Some big databases have been collected for other purposes but have a rich enough data set to begin to work with it.

We collected the data in the support study around decision-making but happened to have enough data to answer a lot of questions about how people die. But there's nothing that combines Medicare utilization with clinical data in a population enriched enough for serious illness to do much with.

So most of the surveys will catch the population prevalence of serious illness, which is 5 percent or 10 percent, so you end up working with 300 patients or something, which is still a little illuminating but you're not sure you can generalize it to the Medicare population from that base.

So I think we probably would need over time to start developing some better databases but you can still do

so much with what you have in Medicare billing if, in fact, you jumped the question of whether I'm right that a hospitalization with CHF is enough to show that you're really sick and said if that were true, then what flows from it, you could do a whole lot with utilization straight out of the Medicare data utilization.

We have such enormous small area variation where hospice penetration goes from 60 percent of everyone dying in some parts of Connecticut to 10 or 15 percent in some parts of the country. Probably you could do fairly easy case control matches, you know, group controls and see whether your overall utilization is looking different and then you could do focused interviews to see if the experience of people going through these very different patterns looks different. The variation is so enormous.

We're publishing a paper next month in the journal American Geriatric Society that shows that we can explain 88 percent of the variants across hospital service areas in where you die on the basis of billing data and 81 percent of that is in how many beds you bill per beneficiary. So the variation in 60 percent in Newark and 20 percent in Phoenix,

or roughly that, is statistically highly correlated with your bed supply.

Now does that mean -- field of dreams is our metaphor -- you have to build them and they will come or the policy planner's dream of if you close them, they will go? Probably not. My guess is that when you look at a place like Newark, people don't have homes capable of taking care of them as they die.

People don't have family structures that the kind of support that's available is very, very frail and that we will turn up things like my guess, my hunch, with no good data is that one of the biggest impediments to family care of people who are very sick is the fact that 50 to 65-year-old women who leave the labor force are too expensive to reemploy because of their health insurance.

So that if someone who's made their living changing sheets at the local motel has to give up work to take care of mom, two years later she will not be able to find a job because her health care costs are too high. That might be true and it's quite approachable in some policy issues, agendas, but that it seems the data probably is out

there to start measuring.

How big a problem do people have getting reemployed at those ages? And what do the western European countries do that have a substantial program of job protection and partial payment of family to take care of seriously disabled people? The only category we cannot pay in Medicare is family care givers. So many other countries have a different approach. What did they learn? Does it do better? Does it do worse? What does it do to family structures?

I don't know but I'd like to know. Maybe there's a whole bunch of things in there. Did you have some other thoughts?

DR. WILKINSON: Just that we're going to have to create some of those databases just because they aren't out there at the moment and there are certainly some potentially with the large staff model HMOs who now have a substantial elderly population. Accessing that data is another issue but certainly we're hoping through demonstrations like the Medicare demonstration to be able to create enough of a database to begin to address some of the questions and point

to further areas of needed research.

DR. WILENSKY: Let me just ask, as a research question it would seem to me that a different way to approach it would be to do matches between the MedPAR files and the common working file on diagnosis and then to be able to tie that into the mortality rate statistics to be able to look at identifiable diseases, especially since you're only talking about two, three, four diseases that are of primary interest to look at both the experience in whether or not they end up at death to try to get a better handle on what happens to individuals with say CHF or COPD?

DR. LYNN: Sounds like it would work. I don't know the typical details but the -- I mean I don't know which problems you'll run into. I'm sure there would be some but you probably would want to do some basic methods work as to whether some of the assumptions on diagnoses work well.

How much can you infer severity off something like frequency of utilization? The fact that we have almost no databases include drugs is a substantial challenge because that would be the easiest way to start checking for severity

but we don't have that. So all we have in billing sorts of data is frequency of utilization which probably also responds to local patterns and not just to disease severity.

DR. WILKINSON: As well as payment incentives.

DR. LYNN: But it seems like it would be a promising direction to go.

DR. KEMPER: The long term care survey might be another one that's linked with Medicare claims. Thank you for your vision of a care system at the end of life. I think it really places a marker out there.

I wonder if you could reflect a little bit on how we might get there, particularly immediate steps that might be taken. We've talked about education of physicians and consumers. You talked a lot about research and additional information that would be useful. You talked about risk adjustment as a very promising approach for doing this, perhaps a bit more sanguine than some of the Commission's work on the risk adjustment in terms of how well things can be predicted and so on.

I guess assuming that the risk adjustment is effective, can you say a little bit about the likelihood,

the incentives that the plans would face and the likelihood that plans would have the right financial incentives to actually make these changes in the care? Are these services additional services that might not be really substitutions for defibrillators or whatever more intensive care is there; and how would that play out on the one hand?

On the other hand, for the bulk of the elderly under the fee-for-service system how could one change incentives to create this kind of care system given that you would never take away under fee-for-service system incentives to treat in an intensive way. So how do you actually move in this direction?

DR. LYNN: I'll try to hit at least a few high points that stimulate some thought. I think I probably can't keep track of all the pieces. How do we get there? I think in part we must develop some personnel who care about this. The project on death in America having funded 30 academic, mostly physicians, a few nurses and others to work in this arena has given it an enormous jump start.

Why are we out there as the only research academic institute devoted to end of life care? Why isn't there a

GREC or two? Why isn't there a Pepper center or two?

My guess is in five years there will be but there need to be a cadre of people who are committed to developing information that would guide change and to be critical of one another and to reflect on the methods issues. All of our accounting is done on a per-person basis so we talk about cost per beneficiary.

Once you get into this arena you've got to deal with length of life so if you have two different patterns, one of which gives you an extra month, that extra month swamps almost everything else in your analysis and yet how do we want to value it? There are serious methods issues that have not really been played out and there need to be some people doing that. Then it seems there needs to be a real enthusiasm for innovation.

We just finished work with 48 sites around the country in a quality improvement innovation endeavor with the Institute for Healthcare Improvement trying to improve end of life care sort of in everybody's backyard. What can you do today right away? About 40 of those sites made big strides. They did things like cutting pain rates to a

quarter.

One site took dysnea, that's shortness of breath, from 55 percent down to one or two percent. They made enormous differences in community services, hospice referrals. This was 40 ordinary managers out there trying to improve their own system within the current incentives.

There's only so far you can get within the current incentives, but there needs to be in a sense an enthusiasm for a lot of innovation. When you get to the policy sorts of things I think the first thing is attention in high places, the kind of thing you're doing today. The kind of thing, putting your chapter in last year has really made a difference, the IOM report that focused on end of life care.

It helps begin there to be a language in which people start learning how to ask the questions that matter. That helps a lot but then as you get down to specific policies, what kind of things could we try out?

We could try out, for example, trying paying the real Medicare rate, the fee-for-service doctors who ordinarily provided continuity services and cut everybody else in half. I'll bet we'd learn real fast to do

continuity. We could think about fee-for-service in the hospice kind of approach where there's a highly skilled team that does the core services.

But the doctor is still a Part B biller and still in fee-for-service. Provides an interesting check on quality because the doctor is kind of outside and can be a critic, but also insures that the doctor who only has three or four patients like this is buttressed by a system that really knows what it's doing and it insures continuity and is attentive to the whole range of issues.

I'm not sure which one of these or the 20 next ones I could name will work but what we need it seems is a decade or so here where we're really enthusiastic for trying out those things with careful evaluation, reporting back, learning what we need to know in order to really fundamentally reform the system so that the degree of reform we need to have comes through. I'm not sure what.

I keep telling medical students the hardest thing I have to teach you is I can't tell you what the system ought to look like 10 years from now. If it looks like the best we do today, it's out of place. The best we do today

ought to be anachronistic 10 or 12 years from now because the best we do today still has people facing terrible discontinuities and uncertainties.

Even if you have a doctor who is terrific, you'll still face whether your insurance will cover the things you need and whether your family will get support. So the idea that we need such fundamental reform that even experts in the field couldn't tell you exactly what it ought to look like is disquieting in medicine.

Doctors are the group that took 12 or 13 years of multiple choice exams. We're used to thinking there's an answer. It seems that the answer at this point has to be the willingness to try things out and to carefully learn quickly what it is that really works well.

How do you take care of a huge population of dementia patients efficiently, high value care so the families are not routinely wiped out, strapped down, have their lives ruined, but you also haven't turned your back on dementia patients? How do we take care of COPD and CHF?

We've decided that if hospice can be fixed up, it might well work for most cancer and the dementia looks like

too big a job to tackle. So the one we're going after right now is organ system failure, heart and lung disease. If you could figure out what really good care looks like for heart and lung disease over the next three or four years, could we also be politically ready to make the changes necessary to align the incentives with the good system?

Right now if I routinely walked out on patients with pain, I routinely did not treat them, my chances of ever having my knuckles cracked over that are almost infinitesimal. We have to change. And if I do it routinely, I don't get paid well. I mean what we value shows and we have not valued high performance in this arena until now.

DR. WILKINSON: And like anything else, Medicare really leads in both payment mechanism and I think could lead here in quality of care. And by focusing on creating the environment to allow innovation to answer some of these questions in the policy arena and we have demonstrations like MediCaring or any of the other great ideas that are out there, we change even that 40 percent of care. It's going to filter down into all other areas of care.

Quality can become our touchstone, that really just takes kind of the first few steps. Certainly I would argue end of life care is one of the best areas to start in because we're all going to be there.

DR. LYNN: Three-quarters of us die on Medicare. If three-quarters of us were born in Medicare, there would be some standards. What is good prenatal care? What do you have to be to be a contractor? It's astonishing, there are no standards.

DR. LEWERS: I, too, would like to add my thanks. I've been living in this world for a long time. I'm a nephrologist. You talk about a population that we have a lot of data on and nobody has bothered to look at it. Almost 30 years of data with a federal program that no one has taken a good look at. A major portion of the patients are rehabilitated, they go on to transplant but the others end up in care at the end of life. It's a slow end of life. Nephrology has had trouble dealing with it.

If you look for a model, I doubt the way we pay for that is the model we would want to assume. Have you done anything in looking at the end of life care in the

nephrology population and the vast amount of information that is available?

DR. LYNN: Only a little bit. I'm glad you brought that up. There is a tremendous database in end stage renal failure now that includes some quality of life measures and so on. They're beginning to include some advanced directive at least reporting so it's at least there. No one to my knowledge has plumbed that.

I know from people who work with it that it appears that the variation that we see in everything else in end of life care is also present in this very big federal program so that in some areas more than half of people end up dying with a deliberate withdrawal of dialysis and in other areas it's almost unheard of. It essentially never happens. Probably there is something going on there and one would want to understand whether people who never stop dialysis, whole groups who never stop it, never have it presented as an option or whether they have very different preferences, as you were intimating before, or whether the groups that are at very high rates are in essence getting pushed. Aren't you sick enough now or we're talking to

their family.

I'd be very curious about that and here's a database in which you'd have a lot of national data to look back on. I've not worked with it at all but it's a promising idea.

DR. WILKINSON: Good idea.

DR. LEWERS: There's actually two databases because you have the Medicare database, but you have a number of private companies that really do have an extensive database in relation to this. So it's an area I've talked for a long time to people about trying to do something to take a look at what we can learn from this but everybody seems afraid of it. I don't understand what the fear is to enter into those databases. It's there. There is a fear for some reason. I don't know what it is.

DR. LYNN: People are very worried about, and it's reasonable for you all to be worried about it too, about there being any appearance of an interest in how long people live on the part of people paying the bills because there is a real fear, and I think a reasonable one, that we will be overly interested in curtailing our costs that can translate

into living less long. No one is more costly than a long term disabled patient and life itself is what costs.

It is an area in which we ought to take the community along with any experts. We ought to be talking about the ethics issues in public. It's a terribly troubling arena when you really must realize that the big cost in a dementia patient isn't anything covered in Medicare, it's the life itself. It's the day to day care. It's the toothbrushing and the turning in bed.

So I think the reticence arises from a real fear of being perceived to be interested in curtailing costs for less than noble reasons.

Something else you said though raises another observation which is that the payment for end of life care that is not curative turns out to be a very difficult ghost to track. The erythropoietin story I think is fascinating. I don't think I've tracked it all down yet as to how he ended up getting covered for a drug which can be taken outside of a doctor's office although you can't be covered for narcotics. Now why is erythropoietin covered and my pain medicine is not? They're both symptom relievers.

The coverage decisions that result from some of these sort of by the ways might be very illuminating but when we go to big programs, you know the program at Mount Sinai, the program at Sloane-Kettering and the program at M.D. Anderson and say how do you manage to stay afloat? Nobody knows. Nobody knows what Medicare is paying, which bills get paid, which things get cross-subsidized, you can't really build a field if no one is sure that they can make a business decision to go into it.

DR. WILENSKY: I'm going to ask you in a minute if you could very briefly summarize for us what the MediCaring demonstration is about so that people who haven't had a familiarity can just understand.

Peter, and then I think we need to stop.

DR. KEMPER: This is a quick question I think. I may not have the numbers right, but I think you said something like 80 percent of people have these long deaths are accounted for by five conditions.

DR. LYNN: Eighty percent of people have one of five conditions in the year before death. We don't know that they died of them but you look at all their diagnoses.

DR. KEMPER: Do you know what percentage of them are in nursing homes or some sort of long term care facility?

DR. LYNN: Since it's essentially everybody in Medicare those are readily available. It varies enormously across the country. The number of people who are --

DR. KEMPER: No. But I mean the percent of that group with those --

DR. LYNN: You mean who die in nursing homes or who live in them?

DR. KEMPER: No, with those five conditions, who have gotten to this, your end stage with those five conditions, are many of them in nursing homes or not?

DR. LYNN: Yes, many of them are in nursing homes. Many are nursing homes, probably the biggest arena of growth for end of life care is going to be nursing homes. In Oregon now more than a third of patients are dying in long term care facilities, not even being transferred to a hospital. Probably nationwide it's more on the order of about 17 or 18 percent on the national figures.

One would guess that Oregon is the wave of the

future, that as hospitals become more hostile environments to people who are dying, nursing homes will be asked to pick up the slack.

Now under the PPS system they will have incentives not to develop expertise in this arena because it would be to their advantage in skilled situation, Medicare paid situations to move people back to the hospital. So there's sort of a conflict of incentive here. I'm not sure where it will end up resting but nursing homes even more than hospitals have enormous variation.

A friend called me recently with a 600-bed nursing home that until recently had never developed a method for locking narcotics because they had never had them on premises. A 600-bed facility with an annual death rate of probably on the order of 150 or 200 never gave a narcotic, all the way to facilities that are quite proud of managing patients right through to death.

One I worked with had 80 percent of everybody who died, died in home, that is in their home, in the nursing home. And the reasons for those very different performances have never been checked out.

DR. KEMPER: So in terms of a payment policy, that means that this system of care at the end of life interacts a great, the Medicare piece of that interacts a great deal with the Medicaid nursing home and state home care as well. So it's part of a much bigger complex there in terms of payment.

DR. WILENSKY: Anne, do you just want to give a couple minute description of the MediCaring demonstration?

DR. WILKINSON: MediCaring has grown out of both the support study and the experience gained in good hospice care, good paced programs and good palliative care. And the idea is to transfer what we know about good management at the end of life to the majority of people who are dying since hospice only covers about 20 percent of all dying patients in any one year and because the majority of those dying are in other institutional settings and the limitations of the service delivery in hospice make it very difficult to do that.

MediCaring is designed to redesign the incentives, the payment structure and the care delivery environment to meet these, what we would call comparable needs for end of

life care. Things like team management that can follow you across any care setting and that are responsible and at risk for that care through the end of life. A 24-hour response capability in which any problem that comes up in the home, the family has a place and a person that they know they can call and have confidence that that person knows their situation and has a way to address their problem, whether it's through the telephone or bringing them into an institutional setting.

It's management across all settings and its focus is prevention of care, prevention of crises, prevention of some of the things that we see happening to CHF, COPD patients right now. Symptom management is the goal.

So taking again all of these components that we know work at this moment and providing a payment system and an environment of testing to see if the models that we think are going to work and that seem to be working in small scale across the country right now can, in fact, be made into a universal system so that the usual person coming to the end of their life, like the vision that we talk about, can be confident of the system of care they're going to be

receiving and confident that the team that will be managing their care, will not abandon them, will be the person that is there with them to the end, and that they will have what they might call, the family can say after the death that this was a meaningful experience.

DR. LYNN: Just kind of the nuts and bolts of what we're proposing, actually we're sure we're going to be doing, 40 sites in a collaborative, quality improvement mode starting in January or February trying to do this ferment of innovation I was talking about. And then probably in about March to put online 10 sites that do not need waivers to start in a research mode of research quality data, enrolling at least 100 patients a year.

And on the order of about two years later to be in the position to request waivers so that more generalizable sites can join in with the hope that then on the order of four years from now we would be able to say, here's what good services look like, here's how much they cost and here are the kinds of payment schemes that might work. The next phase would be for HCFA to try those out.

DR. ROWE: Who's funding this?

DR. LYNN: We have half of the funding in sites from the VA, the Archstone Foundation has just agreed to fund some of it. A good deal of our vision is being self-funded by the sites that are participating and then there's a chunk still left out there hopeful to be covered, yes.

DR. ROWE: I'm already funding them. We want to know how you keep these programs going. You support it from some of that other enormous, in patient PPS margin.

DR. WILENSKY: Thank you very much, Anne and Joanne. We're going to open it up for public comment if there is anything that people would like to raise at this point.

DR. WEISS: I'm Harold Weiss, physician. Before working for the Delmarva Foundation, the local PRO, I served as a pulmonary physician and director of residency program in a local hospital where my contact was primarily with COPD patients at the end of life.

The difficulty that I faced was working with patients and their families, having gotten them to the point where they were willing to accept that when the time came for the disease to have run their course, having counseled

them what will happen and having had them agree that they would not wish to be on a ventilator and sign the appropriate forms, invariably or at least in many of the cases that I dealt with, two to three hours or four hours prior to the time of anticipated death, there would be a sudden change of heart.

The families would say I didn't realize it would be this difficult to see my loved one go. I don't think we want to persist with these things that we sign and we want mom or dad back on a ventilator. In one case they even brought a letter from a lawyer challenging the mom's signed statement was valid because of the low oxygen, high PCO2. So the challenges, therefore, are both education of families as well as education of providers.

However, my recent experience with the PRO movement warrants my suggestion that perhaps when we do health care quality improvement projects which we are involved in, most of which include the diseases that have been mentioned that result in end of life for Medicare patients, that perhaps there ought to be included in these quality indicators not so much what should be done, which

are relatively easy to establish from clinical data but perhaps there needs to be a database as to what shouldn't be done and what are those quality indicators.

It's easy to say that a patient with pneumonia should get antibiotics which is a current study in progress, but is there data to suggest which patients should not and can quality indicators be developed that are acceptable to the medical community and to patients to develop those kinds of quality indicators and add them to the studies that we do involving diabetes, heart failure, et cetera? Is it feasible?

I would ask the presenters to perhaps comment on that.

DR. WILENSKY: Thank you, but I think what we will do is these are issues that will be coming up in our afternoon discussion. We're going to basically spend the afternoon talking about quality assessment strategies. The meeting, of course, will be open and you may want to stay to listen to the discussion by the various groups who are doing quality assessment.

Unless you have another comment, we're going to

break for lunch and I'm going to ask the commissioners to be back for an executive session at 1:15. Be sure to be back here at 1:15 so we can have a 15-minute executive session before we open again.

MS. METNITCH: This is more of a methodological comment. I'm Rene Metnitch from the Health Care Financing Administration and we actually do have a longitudinal database that we've built where we've linked Medicare expenditure information to the SEAR data with the National Cancer Institute and we have a fair number of years that we've linked. It is confined to patients that have been diagnosed with cancer, but it's a fairly rich database. It allows you to examine a variety of different questions. So it's just more for information.

DR. WILENSKY: Thank you very much. Murray has told me that the people who we were going to have be presenting to you in the executive session are not going to be here at that point so we will just wait until 1:30 to reconvene.

MS. GAGE: One more comment. Dr. Lynn has urged me to stand up. Barbara Gage with the Urban Institute.

We're also doing some of this work in a project funded by ASPI to look at Medicare's hospice benefit and how it's being used. So we're doing some comparative analysis of the 1996 benefit, who is using hospice; how long they're using, et cetera. And doing some comparative work with the decedents, looking at who went on hospice and who didn't.

We're also subcontracting with Brown to do a little study of the nursing home population using the MDS data which I think came up this morning to look at some of the differences there as well as to who was on hospice and who isn't on hospice in the nursing homes controlling for certain diagnoses.

DR. WILENSKY: When do you anticipate the study will be available to the outside?

MS. GAGE: We're expecting the data to arrive any day now but we're also doing some front end work which you guys might be interested in, in terms of interviewing both the nursing home industry and the hospice industry as to how they define the hospice benefit or palliative care or end of life care because there seems to be some real definitional problems and we'll be happy to share that.

DR. WILENSKY: Would you? Again, I don't mean to press you too hard on this. Is it like, do you think a six or seven-month period once you get the data that you would have information available? My main interest is, is it something we may be able to see prior to either our March or our June reports?

MS. GAGE: Prior to your June report.

DR. WILENSKY: Thank you very much. Any other comments from the public?

DR. CASEY: I'm Don Casey, I'm an internist and I work with Harold. I just want to make an observation about teaching. I appreciate Dr. Lynn's comments having taught and also practiced in primary care and taking care of a lot of end of life people. I appreciate the sensitivity to that.

But I would challenge this commission and also those involved with these research activities to consider the preferences and attitudes of the caregivers because I think that the outcome of their performance is as much a function of their own internal feelings about death. Anyone who has taken care of patients knows what I'm talking about.

So I would encourage a sensitivity to that.

DR. WILENSKY: Thank you. We will reconvene at 1:30.

[Whereupon, at 12:37 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:29 p.m.]

DR. WILENSKY: We don't have all of the commissioners back from lunch but we have most of the commissioners back from lunch. So I think because we're aware that all of you, not surprisingly, have time constraints and we're very appreciative of the fact that you've been willing to give us some of your valued time as we look at these issues, we're going to start the afternoon panel.

On the first panel we have four individuals. I'm going to ask Beth Docteur who heads our area of quality to introduce you. If we can have David Lansky, Peggy O'Kane, Dennis O'Leary and Randolph Smoak come join us up here, I would appreciate it. Beth, would you like to just introduce so we know which groups we have?

MS. DOCTEUR: This afternoon we have a series of three consecutive panels who are here to provide us with information and some expert opinion related to one critical issue on MedPAC's agenda this year. That issue is how can Medicare best use its power as a health care purchaser to

improve the quality of care that's obtained by Medicare beneficiaries.

Our first panel is here to bring us up to speed on some of the key mechanisms currently used for quality assessment, particularly health care quality measurement and accreditation systems. We'll have the panelists each give a short presentation and then leave time at the end for questions.

We have with us today Dr. David Lansky who is the president of the Foundation for Accountability or FACCT. This is a non-profit organization that focuses on helping consumers make more informed decisions about their health care.

Our second panelist will be Margaret O'Kane. Ms. O'Kane is the president of the National Committee for Quality Assurance. This is the organization responsible for HEDIS as well the HEDIS measurement set as well as a leading health plan accreditation body.

Next, we'll hear from Dr. Dennis O'Leary, the president of the Joint Commission on Accreditation of Health care Organizations. His organization is responsible for the

accreditation of hospitals, home care providers, hospices and many other types of health care organizations.

Following Dr. O'Leary we'll hear from Dr. Randolph Smoak, the Chair of the Board of Trustees of the American Medical Association. Dr. Smoak also chairs the governing body of the American Medical Association's new physician accreditation program. He'll tell us about that today.

Your meeting materials include additional biographical sketches of our panelists so without further adieu, I'll turn it over to Dr. Lansky.

DR. WILENSKY: If I can ask your help in trying to make sure we have enough time for the commissioners to have a dialogue with you, if you can be sure to keep your comments to between five and 10 minutes. The most interesting thing for us, and I think probably for you, will be if we can maximize the amount of time we have for exchange with each other. Dr. Lansky?

DR. LANSKY: I do have a set of handouts, pass that around if we could. I'm sorry there aren't enough for all the other guests but I'll be happy to make them available if someone wants to contact me later. These are

overheads. I won't show the overheads. Let me just talk through them with you briefly.

First of all, thank you very much for inviting me to join you today. I appreciate this opportunity to be with my colleagues and help talk about the challenges for the Medicare program and quality assessment.

I won't go through all of these slides if that will reassure you I hope. I just want to talk about a few of them and give you some highlights of what we're doing. I gave you more than you needed as background but don't be alarmed.

DR. WILENSKY: We were given this. We do have some background.

DR. LANSKY: FACCT was formed about three years ago by purchaser organizations both public and private and by consumer organizations. You'll see from that second slide in the packet, HCFA sits on our board of trustees with two representatives. It has since we were started. We are very much board driven rather than say staff driven. That is we try to understand the needs of the organizations on our board of trustees which you've had in the previous

material. We have several federal purchasers, federal employee benefit program, the Veterans Administration, for example, are also on the board.

Initially, FACCT was focused on developing outcome measures that could be used in various purchasing and performance measurement systems such as HEDIS or ORYX as well as in direct use by purchasers. Frankly, our role has changed some and we are now still in the business of developing outcome measures and reporting measures. For example, we're very active in the children's health arena right now in support of the CHIP and Medicaid programs in children's health.

But I want to talk to you today less about specific performance measurement strategies and more about the ability of consumers to make decisions. Our work has evolved recently to really a greater emphasis in the case of the Medicare program on the beneficiary's ability to make choices based on seeking high quality care for themselves and their family.

And as obviously we attain an individual choice model of the Medicare system, it provides an unusually

interesting vehicle for examining how do you individuals make decisions and will that decision making power change the health system. While there are obviously regulatory strategies and quality assurance strategies that are relevant to the improvement of the health system, our particular role is to emphasize the ability of the informed consumer to change the health system.

In terms of modern times, I think there's probably no other role we have in life, other than health care, where we have as little information and opportunity and power to shape the care we get. So our interest is in changing that.

The two in particular we've developed is on the top of the second page of the handout, the consumer information framework. This was developed originally under contract to HCFA which was completed in June of '97. HCFA, anticipating BBA, recognizing their growing responsibility to provide information to beneficiaries asked us to look into what do Medicare beneficiaries want to know, what do they think quality is; how do they make decisions; how could we, HCFA, provide information to the population we serve so that they can make better decisions and choose either

systems of care under the BBA options or individual providers of care if they're retaining traditional Medicare?

Since then we have validated this framework with federal employees, benefit program employees, Medicaid in some states, diagnosed populations. It has been used in various forms by a number of organizations and systems. Several states are using it to organize information for both Medicaid and employee populations. The Federal Employee Benefit Program is using it to organize information for federal employees. NCQA has made an adaptation of it for use in accreditation '99. So we feel like it has had some impact in a way of organizing information for consumers.

There are three parts to it I want to very briefly touch on, on the second side on page two, that we approach this, and again I'll just emphasize we are beginning with the question of how would Medicare beneficiaries make decisions that would reward better quality care, both for themselves and as a signal to the health system to reward quality in the original paradigm.

There are three parts to this: communications, messages, a model for information, presentation and the

measures themselves. I'll talk just briefly about each of those three.

The idea of the messages is one we came upon frankly fairly slowly and late. We did a number of focus groups with different groups of consumers around the country including in the Medicare program and discovered perhaps to no one's surprise that relatively few people in the community as a whole believe that it is their job or they have the power to make important health care decisions.

There are a number of ideas that we call myths that prevent people from feeling that they are empowered consumers when it comes to their health care choices. One thing we identified were some messages to help debunk those myths and give people a sense of their autonomy.

An example of the kind of myth I'm referring to is the idea that quality is the same everywhere. I may as well choose this doctor or this hospital or this HMO as another because there's no difference in the kind of care I or my family is going to get.

As long as people believe that, we have plenty of evidence that says that's not true, as long as people

believe it, there's no reason to make a decision that favors quality. There's no reason to seek quality information. We collectively have a responsibility we think to alert the American public that quality varies substantially and their decisions are very important to their health and to the American health system.

So there are some messages you'll see in the middle of page three that we have been testing to help people understand the importance of these decisions that they make when they enroll in an HMO or when they select a physician.

Quality matters, not only cost, not only access but quality really matters. We need to talk about that more than we do. Quality varies enormously. You put your health at risk by making a decision of where you seek care and you need to understand that. Quality can be better than it is. That's consistently true almost everywhere we look. And that you, the individual consumer, the American citizen can make a difference in the health system by thinking about quality and taking actions to seek out quality care.

So that's an empowerment message and strategy,

which as I'll say at the end, I think is an opportunity for the Medicare program to embrace as it follows, as it executes the BBA strategy.

The second part of this model is called the model, the framework is the model. You'll see at the bottom of page three a five-part model described or mentioned. It's given in some detail on the following pages. The model contains five parts to it and essentially what we're saying is you can produce a consumer report card which contains five grades or five scores in it describing the quality of care available from an HMO, PSO, a delivery system, a medical group.

We can talk about the units of analysis at another time, but what people care about when we talk to them on the street are five things. Will I get the basics? We think of that as service, quality, access communication, partnership in decision making.

Secondly, will they help me stay healthy? Will this health system help me to stay healthy? Prevention, health promotion, health education and so on.

Thirdly, if I get sick, will I get better is the

phrase people use. Do they help people recover levels of functioning and health in light of acute problems where recovery is possible?

Fourthly, if I'm not going to get better, I have a chronic illness like hypertension, diabetes, asthma, heart failure, will they help me live with this illness, manage the symptoms as best as possible, maintain functioning as best as possible?

And finally, we call changing needs, if I'm really in a downward spiral, my health status is fundamentally changing. I'm facing death, disability, permanent long term care, change in my health status, does this health care organization help me and my family, my care givers go through this inevitable transition in my health status?

We think it's possible to develop a grade, a performance score for each of these five categories of quality that people on the street talk about all the time. We've not really given them a vocabulary of quality, and this is an attempt to introduce, think of it as the columns of a Consumer Reports report. So we were working down that path.

Let me skip to the third area that we're working on within this framework. And by the way, I'll show you at the bottom of page five that chart that illustrates the assignment of quality measures to these five categories is just to illustrate that given HEDIS, given ORYX, given the CAHPS survey and other tools that are out there, disenrollment rates in the case of Medicare, for example, it is possible to assign those individual items to these five categories I've suggested to you and then compute a score.

We've been doing a lot of work with various state governments and private purchasers to compute those scores based on the available information that we have today. The final of the three parts is the measurement strategy. You can look at the slides on page six and seven about that. I just want to mention the way we approach this has a very strong consumer input component to it.

We do focus groups with patients and family members who have been affected by these illnesses. We get expert opinion. We get health services researches and clinicians to write background papers describing the state of the art in measurement in these areas, then we couple

consumer requirements of what consumers think quality is with what experts think quality is to build a measurement set around these problems. And I'll let you look at that at your leisure.

We have them as you'll see on the top of page seven for a number of clinical areas, such as breast cancer and diabetes and some population-wide circumstances such as end of life care and health status measures. On the bottom of page seven you'll see what we think should happen next to move this field along, which are really two strategies. One is to organize what we now know into these five categories so that as the HCFA program has access to CAHPS data, health of seniors data, HEDIS data and so on, we would encourage them to organize what they know about quality of care into these five categories so that consumers can understand it using simple language and a simple framework that is acceptable and valuable to the consumer.

But secondly, we use these five categories as a gap analysis, as a map to what we don't know. When we take the measures that are available today through the hard work of my colleagues here and put them up against these five

kinds of interests that the public has, we find some things missing. We're not very well able to speak to the public about the quality of long term care, about the quality of end of life care, about the quality of serious chronic illness care. We think those are opportunities for measures development. Those are the two strategies we think should be pursued.

Let me just conclude with a couple of thoughts specific to HCFA, responsibility and programming. You'll see at the top of page eight my last couple comments. I've encouraged the Medicare program in particular to be an advocate for consumer quality decision making as a part of the messaging and education strategy they undertake. I do think it's possible to make this work. I don't think we should dismiss it casually.

We do know what beneficiaries want to know and we know how to communicate to them. We know how to measure it. We can get on with doing that. I think having a framework for communicating to the public is as important as standardizing what we measure. Hope you consider the communications challenge equal to the measurement challenge.

Thank you.

MS. O'KANE: Thank you for the opportunity to talk to you today. I'm going to start with some general remarks about NCQA. For those of you that know us, bear with me.

We're a working partnership among health care purchasers, consumers, managed care plans and quality experts, so you'll see that kind of a stakeholder representation on our board of directors and our committees. We were established in 1979. We were closely related to the HMO trade associations until 1990 when we went independent. We're an independent 501(c)(3) non-profit. You should have a handout at our place, I forgot to mention that, and there should be enough for people in the audience as well.

Our vision is really of a value-driven marketplace for health care where everybody in the system is accountable for the quality of care that they deliver. We think that that requires standardized measurement. In this vision, consumers and purchasers are empowered with information when they make their choices among health plans. Health plans ultimately need to be empowered with information as they are

contracting with providers. Suppliers compete on both cost and quality.

Now, when I started working in health care, when I was in graduate school, we learned that there wasn't any competition in health care. Today we have competition in health care and it is price driven competition.

So I think that there is precious little value driven competition today. We think it's a very critical agenda because the result of price competition we think will be to harm quality. So we see this as extremely critical. Our current approach to quality assessment has two programs. Our accreditation program and certification programs that basically feed into that.

We've had pretty good luck with that because of the support of purchasers that mandate NCQA accreditation like Ford, like GE. 51 percent of HMOs are in the process or accredited already but that actually belies the impact because 75 percent of HMO lives are implants that we've accredited.

The other piece is HEDIS, the Healthplan Employer Data and Information Set which is basically a standardized

way of looking at how well health plans achieve clinical results and other kinds of results. Examples of some of our HEDIS measures are breast cancer screening, beta blocker use after acute myocardial infarction, smoking cessation, counseling, prenatal care, immunization of children and teenagers. There's now a standardized member satisfaction survey, beginning next year it will be merged with the CAHPS survey.

We think that these common measures make meaningful accountability possible because it's only by bench marking across organizations that you're really able to identify outstanding performance and also sub-acceptable performance.

We started this work with a heavy emphasis on preventive services and as we move forward, we are now trying to address some of the areas that David mentioned which are really much tougher to measure, like how well are the chronically ill treated within health plans? How do we select measures? We have basically three types of evaluation that we do. Relevance to purchasers and consumers, and we've done formal focus group work with that

and some surveying as well as having these representatives on our committees.

The scientific validity of the measures and feasibility, which is always a big issue because it turns out that even gathering what seems like pretty simple minded measures is quite a task for the health plans. We have several new HEDIS measures coming online in 1998. These do address care of the sick.

One is a measure of cholesterol control after a patient has a major cardiac event. The second is management of antidepressant medications for patients that are treated with medication. And then there is a whole set of diabetes measures which were developed in collaboration with FACCT and HCFA and the American Diabetes Association, called DQIP. The new consumer survey also is coming out for implementation in July of 1999.

One of the things that we're most excited about is that we are now beginning the integration of performance measurement into the accreditation program. So we think that how well you do in achieving these results ought to have some kind of an impact on your accreditation outcome.

So starting in July of 1999 there will be 25 percent of the score of the accreditation score will be driven by clinical performance and member satisfaction. The remaining 75 percent will come out of the systems review that's currently the accreditation program.

Why are we doing this? Well, it seems like a very good idea to have a single answer about how well is a health plan doing, although we can go to greater levels of detail. We also have discovered through our work with purchasers that leaving aside the large purchasers who are very sophisticated and can really do wonderful things with the HEDIS data, for a broad spectrum of purchasers like most small purchasers, they've been somewhat mystified by the HEDIS data and really are unsure what to do with it.

So we think that packaging it in this way will also enable us to give them reports that are very, very user friendly and really work for the layperson. So we think that by increasing the power and utility of these two instruments by merging them that we can really drive this quality agenda forward and provide better information to distinguish among plans.

We're at a state of maturity I think with the HEDIS process, although it'll never be finished I'm sure, where we have a meaningful set of measures, always with more in the pipeline, and that's a whole other issue we can talk about in the discussion, but we also have an audit process.

We have 11 licensed auditors now that are auditing HEDIS data. Because since they are self-reported, it's really critical that we be able to trust them. And then the standardized satisfaction survey we've got that whole issue with CAHPS worked out so that there's one out there for the moment at least. We really do hear from our work with purchasers that this is what the market wants. David mentioned that they helped us on this framework and we're very excited about it. We think it does speak in a very user friendly way.

Anyway, so the highlights of Accred. '99, let me reinforce. The score depends on performance. We are continuing to address public concerns. We feel a real need to make sure that we're staying current with public policy concerns since being able to have deeming status is also critically important to us.

We have new IS standards that start to count in the year 2001. We have product type outcome reporting which means we're going to be reporting by Medicare, Medicaid and commercial for the first time as well. Our recommendations to you, there really ought to be core measurements sets at all levels.

Measuring quality is costly. If we don't all coordinate our act, we will all move forward much more slowly and with much more hassle for everybody. Standardization reduces cost and enables comparisons. I said that 75 percent of HMO lives are in accredited HMOs but 51 percent are accredited but 90 percent of HMOs are actually reporting HEDIS. So somehow that agenda really has moved forward in a very rapid way.

We believe that core sets are still needed for providers and institutions and there will be a need to coordinate that and we will be working with the joint commission, AMAP, on the Performance Measurement Coordinating Committee. So we really have to think I think if we really want accountability throughout the system, how can we do that in a way that's very efficient, that doesn't

drive everybody crazy by sending different signals through the system and by driving up cost in an irresponsible manner with no value added.

So we recommend that you promote deeming and we'd like that to be a meaningful deeming process and one that we can work with. There have been some proposals that we are a little bit uncomfortable with. We think that deeming can work really very effectively for a more forceful accountability system and it can be a win-win from our sources' perspective, not only for us, for the regulators but also for the health plans. If we have a consistent approach, we will actually be more effective by sending a common signal to the system.

In summary, we'd like to make sure that you encourage the Medicare program to build on existing work to make sure that core measurement sets exist at all levels of the system. Ultimately, I know we're years away from that but that this is all done in a highly coordinated and coherent fashion and to support the kind of public/private partnerships that we would like to have.

DR. WILENSKY: Thank you. Dennis?

DR. O'LEARY: Thank you. I'm pleased to have the opportunity to present to you the views of the Joint Commission on Accreditation of Health care Organizations. In the few minutes that I have, I would like to focus on the three goals of reducing duplication in quality oversight activities, bringing more health care providers under the oversight umbrella and integrating performance measurement into the oversight process.

I believe these goals can best be achieved by forging an improved public-private sector partnership between federal oversight programs and accreditors. These collaborative efforts offer an important opportunity for the public in general and Medicare beneficiaries in particular to benefit both from the cutting edge expertise and experience of private sector accreditation and the leverage for achieving key mandates that is exerted by the public sector. Reducing duplication in quality oversight activities has been an explicit goal of the Joint Commission for the past five years.

It is evident that evaluation resources are being ineffectively allocated when some health care organizations

are subjected to numerous oversight evaluations while others essentially receive no attention. New federal responsibilities for managed care will introduce additional challenges into this equation. Looking forward, it becomes a practical necessity that cooperation, coordination, and collaboration characterize quality oversight in the new millennium.

In 1994, the Joint Commission launched a major initiative to reduce redundancy in the evaluation of health care providers. As a result the Joint Commission has now entered into formal, collaborative recognition agreements with six other national accreditors that have met our expectations for standards, surveyor training and survey and accreditation decision processes. Additional agreements are currently being negotiated.

The benefit of this initiative is easily seen in the managed care arena. In situations where the Joint Commission is asked to perform an accreditation survey of an integrated delivery system, it is likely that some of the health care providers that are components of the system will already be accredited by other oversight bodies.

Where the Joint Commission has a recognition agreement with those other accreditors, second evaluations of the affected component by the Joint Commissioner are not conducted. On the flip side, the Joint Commission has many partnerships with states that accept Joint Commissioner accreditation in lieu of some or all of their own on-site evaluations for state licensure.

We also have a longstanding deeming relationship with the Medicare program that formally recognizes our hospital accreditation decisions and more recently deeming relationships with home health, clinical, laboratory and ambulatory surgery accreditation programs have been established. These government deeming relationships are highly valued because they provide accountable state of the art quality oversight for the public while also saving significant taxpayer dollars. By their nature, they thus permit government programs to focus on those organizations that are not accreditable or have otherwise become problematic.

Notwithstanding the existing successful deeming relationships, the Medicare program has generally been slow

to encourage and respond to deeming requests. For example, even though the DBA of 1997 directs HCFA to establish a Medicare+Choice deeming program, it appears that it will be late 1999 before HCFA is ready to act upon any managed care deeming request from the private sector.

Further, early indications from HCFA raise concerns that Medicare+Choice deeming may, unlike existing deeming relationships, be framed more as a contractual relationship with accreditors than as an interdependent partnership. This distinction is important in that accrediting body requirements commonly exceed federal requirements causing Medicare certified entities to meet a higher standard of performance than would otherwise be expected if the accrediting body were simply a federal contractor.

We emphasize the need for accrediting body accountability in these public-private relationships. That accountability is essential to any public assurances that are provided and to the ongoing credibility of the private sector and public sector partners. Current accountability mechanisms include bilateral information sharing and various

validation activities. These mechanisms require constant monitoring and improvement when opportunities are identified.

If duplicate of oversight activities represent one end of the spectrum, absence of substantive provider organization oversight is at the other extreme and is just as real. This is a direct outgrowth of resource limitations both at the federal and state levels. Consequently, tens of thousands of health care provider organizations and suppliers participating in the Medicare program, many of them providing high risk services, are going without routine inspections for up to eight years.

Moreover, HCFA appears unprepared to evaluate and monitor the newer models of care that will comprise the Medicare+Choice options. On this point the general accounting office has recently commented on HCFA's lack of qualified persons in the regional offices to determine whether Medicare+Choice types of applicants are meeting quality of care requirements.

According to the GAO, HCFA has "been conducting only paper reviews of HMO's quality assurance plans in

examining only the description rather than the implementation of HMO's quality assurance processes." These extreme but critically important examples underscore the need for and benefits of deeming relationships. Private sector accrediting bodies provide a continuously refreshed reservoir of contemporary expertise, the capacity to assess actual organization performance and importantly, a commitment to be fully accountable to the public sector partners.

In this model, the provider organizations bear the resource expenditure for the oversight process as the cost of doing business. The last few years have seen enormous strides by the private sector in planning for the integration of performance measurement into the standards based accreditation process.

In 1997, the Joint Commission announced the ORYX initiatives that has as its fundamental goal a more continuous data-driven accreditation process which will by definition focus on the performance issues in the individual organization. ORYX has been designed to create the infrastructure for health care organizations to collect,

report and use performance data using measures that are valid, reliable and standardized. Thus, ORYX is an important bridge to the next generation of quality evaluation.

The significant contributions that ORYX offers do not diminish the compelling need for public and private sectors to also work more closely together on performance measurement activities. Performance measurement is costly, both in terms of human and monetary resources and can easily become unreasonably burdensome to the providers participating in multiple measurement programs. The principle goal of a public-private sector partnership in this area should be the development of an integrated set of core measures applicable across all types of providers of care and all levels of accountability.

To that end, the Joint Commission has co-founded the Performance Measurement Coordination Council with NCQA and AMAP and through this joint endeavor our three accrediting bodies are seeking to make performance measurement more meaningful to all types of decision making including public purchasers.

The PMCC welcomes the opportunity to collaborate with the anticipated forum on health care quality measurement and reporting. However, we submit that an even more immediate partnership with the federal government is in order. HCFA has signaled its interest in performance measurement for managed care through its draft QISMC standards.

We suggest that HCFA's interests and capabilities lay the potential foundation for an even more powerful and expanded partnership with the private sector. Absent such collaboration with the private sector, there is by contrast a great risk of significant duplication of effort and the possibility that new government requirements for performance measurement will not benefit from lessons learned in the private sector.

In conclusion, the present system of deeming has served the country well since the Medicare program was enacted. It has been an effective mechanism for bringing needed efficiencies into the system, while also significantly improving the quality of care provided. In a country now faced with growing public anxieties about

quality of care and with increasingly complex health care delivery models, the need for effective public/private partnerships has never been greater.

To be sure, the explanation of deeming relationships will require the front end of investment of energy and resources by the public sector and private sector partners. We submit that this investment will be well worthwhile. Given the rapidly growing sophistication of the quality evaluation process HCFA cannot do this job alone. Private sector accrediting bodies are willing to do the job under public sector oversight and be held accountable for the outcomes.

There are relatively few win-win situations in health care today but this is one of them for the public and for the private sector and public sector agents. Thank you.

DR. WILENSKY: Thank you. Dr. Smoak?

DR. SMOAK: Good afternoon. Dr. Wilensky, members of the MedPAC, my name is Randolph is Smoak, Jr. I'm a practicing surgeon in Orangeburg, South Carolina and Chair of the AMA Board of Trustees. I also chair the governing body of the AMA program that establishes qualification and

performance standards for individual physicians. The program is known as American Medical Accreditation Program or AMAP. We're please to have the opportunity to discuss AMAP and the coordination of various public and private sector efforts to evaluate the quality of care.

AMAP is a voluntary comprehensive accreditation program that evaluates individual physicians according to national standards. These standards, which I have attached to my written testimony, which you should have, addresses five areas: physician credentials, personal qualifications, environment of care and medical records, clinical performance and patient care results. Together these standards constitute a comprehensive review of the quality of patient care of a physician's practice.

AMAP's primary focus is continual improvement in the quality of care provided to patients. To that end, AMAP is establishing standards for physician quality and then evaluating the performance of individual physicians against those standards.

To help physicians improve quality, AMAP will provide each physician with an accreditation report that can

be used to help identify areas for improvement. The reports will in the future include current measures of clinical performance and patient outcomes across a spectrum of plans unlike the current situation, where a colleague of mine receives C-section profiles from three different plans which vary widely. One showed him to be well below the average of utilization. Another showed him to be above average and the last showed him to be average.

Through the accreditation process AMAP also generates extensive information which a hospital or health plan can use to evaluate a physician for privileging and contracting. Our goal is to use this information to improve efficiency and eliminate unnecessary duplication and redundancy in the data collection process. AMAP will provide a complete and accurate picture of a physician's entire practice.

For example, a colleague of mine has to complete 23 applications and host numerous on-site office visits. AMAP accreditation has the ability to accomplish this with one review every two years. One application, one review, and the resulting single set of information can

satisfy the needs of all 23 of those interviews.

AMAP accreditation is open to all practicing physicians. It is independent of a physician's membership in the AMA. AMAP is currently available in three states and the District of Columbia. It will begin operating in at least three more states by year end. Within the next two or three years it will become available nationwide on a state by state basis. More than 3,000 physicians have applied for AMAP accreditation to date and the first physicians are now AMAP accredited. We believe that ultimately AMAP accreditation will become a mark of high quality and dependability helping patients and the public to identify quality physicians.

AMAP is also working extensively with national medical specialty societies and measurement experts. Recently, they convened a meeting of 29 national medical specialty societies who serve as AMAP Special Advisory Committee or SAC. This group, which represents all specialties that have ABMS certification programs, provides advice to AMAP on how to measure physician clinical performance and patient outcomes.

Members of another AMAP committee, the Performance Measurements Advisory Committee or PMAC, along with members of SAC have already formed two working groups. The first, to select measures for use in the treatment of diabetes and eventually 50 other clinical conditions and, secondly, to improve physician measurement systems.

The commission also asked us to comment on how AMAP will relate to other private sector efforts to measure performance. We're pleased to say that AMAP is coordinating its clinical performance measures with activities with those in the hospitals and the health plans. AMAP, like Joint Commission and NCQA, is incorporating performance measurement requirements into its accreditation standards.

Joint Commission, NCQA and AMAP recently established a Performance Measurement Coordinating Counsel of PMCC to minimize duplication and increase cooperation in developing performance measures. The goal is to define measurement that can be collected once and then used in multiple ways.

We're looking forward to our first PMCC meeting on September the 25th. The AMA believes that these private

sector efforts provide our greatest opportunities to improve care and to establish accountability for quality in health care at all levels, individual physicians, hospitals and health plans. At this stage of development in quality measurement improvement, we would strongly caution against any intrusive public sector approach. The public sector typically lacks the flexibility and creativity that the private sector can mount.

We believe that government can play an important role in supporting research and development of methodologies for quality and measurement and risk adjustment. This combined with the private sector initiatives in standards and measures development will provide the basis for a coordinated national quality initiative. An important step in this integration process is a quality forum recommended by the president's quality commission and currently in the planning stages.

We're excited about this forum's prospects for supporting and encouraging the innovative work already under way in the private sector. We believe that our work, along with the work of the other organizations represented here

today would complement the forum's efforts.

Thank you for the opportunity to speak with you today and I would be please to answer any questions that you might have.

DR. WILENSKY: Thank you very much. Let me open this up now to commissioners. You can either ask specific questions directed at an individual's comments or more general issues.

DR. MYERS: First of all, I'd have to say that I've never seen so much quality at one table, ever before in my entire life. The organizations represented here are all at the top of the heap with respect to this issue, and I appreciate your willingness to come and speak with us today as we tackle these issues.

But I would also submit that we still aren't where we should be. If one were to just think about all the patients that are being discharged from a hospital today, I would doubt if very many of them who are, for instance, in HMOs have any idea of whether their HMO is NCQA accredited and would have zero idea of whether it's one year probational or three years.

I doubt if any of them know whether that hospital's JCAHO report was satisfactory or how many type 1 recommendations were received and responded to appropriately. I don't think that any of them will have yet heard of AMAP. Nor would they have been able to check the HCFA database or state licensure or any of those kinds of sources with respect to the physicians that are caring for them.

So I would guess even if you took a subsample of all those patients that are being discharged today who are health professionals and ask them the same set of questions that the positive answers would still be in the single digits or at best the teens. So I think we've got a long way to go.

One of the issues that I think has been referenced indirectly by the new forum that's been created is that each of you in a way is representing a horizontal segment. The fact is although each of you looks at the interaction, factors really targeting consumers, NCQA, HMOs, JCAHO, the hospital and AMA the physician.

The question is how do we get to vertical

integration with respect to quality? How do we really get to the point where we're able to look at quality as a whole rather than the parts and that each of you represent today, then what should be in the long run the action items associated with lack of compliance to whatever that vertical integration produces, especially for those providers, hospitals, HMOs, physicians who are either unable or unwilling to meet whatever the standards are. Should the purchasers take action with respect to those individuals?

DR. WILENSKY: I'm going to ask you to please keep your answers short as you heard we have seven more commissioners that would like to question on the first round.

MS. O'KANE: Yes, the purchaser should take action. I think we feel very strongly that they should put their money where their mouth is on quality. I think one of the problems is that while companies like Ford and many of the leading Fortune 500 companies have done that in a very meaningful way, it really is quite a different picture with the small employers where it seems to be more of a price driven market. There might be something you could do to

help us get to that segment.

I'll stop there, I could go on.

DR. O'LEARY: I'd just remind ourselves that the Performance Measurement Coordination Council is just such an effort to create an integrated fabric and I think particularly along the lines of the very keen interest in quality measurement as opposed to standards based evaluation. I think we can capture people's attention over quality measurement. We can drive the interest from there. I wouldn't assume that the level of knowledge is that low. I don't know what it is but we have experience in our web site, I'm sure Peggy does, too.

We list the accreditation decisions for all 18,000 organizations that we accredit and we've got probably close to 10,000 performance reports. We take about 250,000 hits per week on that web site. Now, hits are kind of soft numbers as we all know but somebody is out there going surfing through our web site and others. So we'll probably never be a household word in America but people are learning more and more as information becomes available to them.

MS. NEWPORT: Thank you. I would like to

compliment all of you on your presentations. I guess from my background, I work for PacifiCare, we are NCQA accredited and have every intent to get those plans that aren't there yet, they're in the process of getting that. So I'd associate myself with all of your comments on deeming. I think that is a very important attribute to getting this moved forward in a positive way.

But I guess the struggle I have, and when I think about this issue, is moving the needle from the beneficiary standpoint at the Medicare level. Those are individual decisions by and large, although the employers are doing more purchasing for their retirees. We're doing a lot of work. We're spending a lot of money and all of it is all to the betterment of measuring quality and outcomes.

But when I go then and look at what we do in terms of educating the public, when we test messages, and I was glad to see you talk about messages, we're still getting basic messages are fine but when you get to the detail that we lose everyone and we're struggling with this as a company. I think we're preaching to the choir to some extent here but in terms of what you do and how you're going

about it but how do we then translate that to something meaningful for the beneficiary when they make their choices?

MS. O'KANE: I think this is a critical gap in the whole market-driven strategy for the Medicare program. I personally believe that first of all we've got to put very simple information out where people can get more if they want it. But I actually believe that for many Medicare beneficiaries the only way that they can be led through this kind of complex transaction is by having a counselor or somebody that will go through the information with them.

So I think that there is a niche for this kind of organization. I know there are in some parts of the country, organizations that are doing an admirable job of helping people translate this information but I think we need to have this happening more all over the country in a much more systematic way.

DR. O'LEARY: We don't understand exactly what people want except health care decisions are extremely personal. I think that the stuff that FACCT is doing is extremely important in that regard, and particularly we as accrediting bodies, and start to translate that into some of

our requirements, that will help.

We get people into hospitals, for instance, or in home health agencies or long term care facilities, again it's very personal. They don't care whether the organization is accredited, too abstract for them. If you're having a hip replaced, you want to know how the orthopedic unit functions. Or if you're having a baby, you want to know how the obstetric unit functions and we are not producing information at that level. I think there are performance measurement opportunities there.

I would caution ourselves at least in acute care setting that the answers will not lie in one measure. There's no one measure that's going to tell you about orthopedic care, whatever. We're going to be looking at groupings of measures, profiles of performance relative to specific types of care. I think that sounds simple but it's complex. But I think that's a goal that we're going to be moving for toward downstream.

DR. SMOAK: To pick up on what Dennis said, I would certainly endorse the last several comments. From the AMAP standpoint, it's not nationwide, at least there is one

hospital if you ask anybody there, they know what AMAP is. But any rate, I would hope that the time will come when patients will ask that very question. If you are an AMAP doctor, it would be very rewarding and I think stand for something very positive.

DR. LANSKY: I think it's important to recognize your point that there are many other agents of communication capability out there that are interested in supporting the strategy. And to the extent that the commission, Congress, HCFA itself can articulate these messages and then enable other users, other communications entities, membership organizations, consumer organizations, publishers, media, about these common themes, that will help ramp this up. It doesn't have to be done through a central coordinated strategy as much as the coordination has to be there. It doesn't have to be executed by one central entity.

DR. ROWE: I join my colleagues in thanking you. I think your individual and joint efforts have been probably one of the most significant value based changes in health care in this country in the last decade. I work at the Mount Sinai NYU Medical Center in New York and I've been the

CO of a large medical center for 11 years. The Joint Commission's change during that time in how they've transitioned from a sort and shoot approach to a quality based approach has been remarkable.

My question relates to some of the other comments and it's about communication. Dr. Lansky, you emphasize this, we have to communicate and we have to have -- your last slide says you need to inform beneficiary appropriate, consistent messages, the consumer communication consistent. Dr. O'Leary is feeling pretty good that people really know what he does because his web site is being hit.

I think that's all good but I just think there's an Alice in Wonderland nature to it. I'm a geriatrician. I can tell you that 45 percent of the people over age 75 can't read or something like that, 40 percent over the people over age 80 are demented. I mean if we're talking about web site hits we get, I think we've got to accept that a strategy for the communication with these consumers.

If you want to say, okay, I'm going to talk with the Medicare consumers and then you interview a bunch of people 65 to 68-years-old, that's one thing. But there are

a lot of Medicare beneficiaries there who are not susceptible to the usual approaches to communicate. I don't know what the answer to this is, and their families are susceptible, and their caregivers and others. But I think that we need to really think about how these messages should be delivered, whether they should be written at all or in other forms.

It's a very important challenge for us and I think as one of the things that's happening in the Medicare beneficiary population is that it's getting older, the average age is getting older and there's more frailty and disability and so I think we need creative approaches. You guys have been so flexible and nimble and creative with respect to many other things I think that you can probably get ahead of HCFA with respect to some of these communication challenges, too.

MS. O'KANE: I appreciate your comments because I'm a caregiver for my mother and she hasn't got a clue about any of this but I think we need to understand that we're just at the frontier of this. I firmly believe that this is all going to look really different in 10 years, that

maybe the idea of HEDIS measures will even seem kind of like a very primitive stage.

But I think that there's an issue that we have to remember, people have to be able to trust the health care system. I think we feel a strong sense of responsibility. I know all of us at this table share that. We have a mutual responsibility I think with the regulatory environment, at the state or federal level, to I think protect people from care that's unacceptable.

Now, I think the market plays a really important role in driving towards excellence. I don't see regulatory processes really ever doing that. But I think we have to remember that we all have a responsibility to make sure that people are not put at risk. So I think we can't get carried away with the idea that just putting information into the market place is the sole answer.

DR. ROWE: That's exactly right.

DR. LANSKY: I'd echo that and say it's probably a 20-year process we're undertaking here and many of us will be eligible for Medicare, perhaps at that time, sooner than later. And we will age in otherwise. But I also think we

should recognize that these decisions get made every day, selecting a provider, selecting a treatment, selecting a risk plan. Someone needs to make those decisions.

The protective strategy which I agree needs to be in place has not yet been shown to elevate the quality of care at the levels we'd all like to see it at. We need to take those who are empowered consumers, whether they're caregivers, adult children or beneficiaries, and give them tools to move the process forward.

DR. ROWE: Thank you.

DR. LEWERS: Thank you. I commend you, and I know you believe, and I believe, that we've only taken the first step, but in the presentations, and I guess Dr. Lansky, it falls into your consumer information framework, there's an area that quality commission brought out that I felt very happy with but I haven't heard anything about it today and I hope all of our organizations think about it, and that is the compliance issue with the patient, and the patient, the consumer's responsibility. In your messages I didn't see that.

I wonder whether you are attacking that in any

way, whether you are educating the patients in their responsibility and what is closing the loop of quality because we can present everything to them. If they don't take that role, then we've done nothing. So I'm just curious, you didn't mention it. It's not in any of your slides and are you having a role in that at all?

DR. LANSKY: The place we come closest to it is in, I call it a partnership model of informed decision making and communication. We have measures which address whether patients are partners in making these decisions and in their care.

Our messaging strategy -- we don't ourselves communicate with anybody, except other communicators, so that I think we have not emphasized that as part of the strategy except to say that health systems and plans have an opportunity to increase patient education and involvement in their own care and address some of those issues in their own.

DR. O'LEARY: Just briefly. We do have patient or enrollee or client, depends upon the term you're using, depending on setting education expectations in our standards

across all of our accreditation programs. I think the issue is in that context becomes how much of what kind of education is enough to get to the objectives?

And I think that part of this issues surrounds definition of those expectations. And as we move more to concrete measurement objectives it will be, that is part of the integration of performance measured under the accreditation process where we can set certain thresholds to see whether they're being met in the health plan, hospital, home health agency or nursing home.

MR. SHEA: Thanks very much for doing this today. It's very helpful. I think it should be helpful to our thinking process as we try to come to terms with what is a somewhat different role not only for the Medicare program but for MedPAC in terms of the kind of recommendations.

So I want to pose a question not so much for a discussion now but for any thought you might have afterwards which is among you, you represent the leading organizations in the private sector that are doing quality initiatives and trying to move this whole process forward.

It would be very helpful to us I think to hear

your two or three do's and don't lists for Medicare. You mention a few of these, the deeming situation, don't be too heavy handed but there are a couple of things, particularly in the near term that you think are critical that Medicare do and do right or it won't make a contribution to what you do, or there are some things that you would say just absolutely stay away from because it would interfere with what you're doing.

Again, this is not so much for discussion now because it's probably too long but if you could, any thoughts you have on that after today you want to send us, I think it would be helpful.

DR. WILENSKY: Let me second that. I think it would be very helpful as we go forward. This is clearly going to be an issue we take up in our next year's reports and anything specific in this area would be very helpful to us.

MR. MacBAIN: The health plan report cards that I've seen report single point data, in fact, reporting conformance to standards but the other side of quality also has to do with variation around the mean or aggregate data.

Dennis and then Peggy, do you have plans to collect data on variation and report that as part of HEDIS four or five?

MS. O'KANE: HEDIS is us, so far.

DR. O'LEARY: HEDIS is theirs. And for ours as well, we are at a point in time behind NCQA and HEDIS in terms of using standardized core measures. Our advisory council on performance measurement is directly focused on that activity. We're going to have our first core measures for acute care hospitals by the end of this year and then its about a year for those measures to be imbedded into the couple of hundred performance measurement systems that participate in our accreditation process.

But the answer is absolutely, yes, answer is a critical component of what we do and there's a clear expectation that we do that and do it well.

MS. O'KANE: On Monday we're actually releasing our next version of Quality Compass which is basically plans that publicly report the HEDIS data to us and we analyze it and we benchmark and we're having a press conference on Monday to share all that. We sell this CD-ROM to purchasers or consultants, a lot of consulting firms are buying it

actually. So benchmarking is absolutely critical to the whole process. The whole comparative evaluation is what drives it.

MR. MacBAIN: The next step beyond that is when you get to the actual quality of care that a single beneficiary receives from a health plan is determined by the physicians and the hospital and other providers involved in that person's care and within a health plan, regardless of where they score on a particular measure, there still may be considerable variation around that mean. Do you plan to include that in the next generation?

MS. O'KANE: We believe that if an accountability system really is working and if a health plan knows that its results are really going to count and they're actually going to get paid more by some people for better results that that will drive them to get the level of detail that they need.

Now, I want to say that we are working on the next generation of HEDIS measures, which is at the organized provider level, the medical group level. We see that as critically important, particularly in markets like California where I think that might be the operative unit

from consumers.

MR. MacBAIN: I guess I'm still not sure we're talking to the same point. For instance, if you use Consumer Reports where you get the little circles, let's say it's for an automobile, based on a sample of one, the assumption is that all other automobiles with that model and year will be the same. The degree to which that information is really useful to a consumer is dependent upon the ability of the manufacturer to produce all cars identically. The more variation there is around the standard the less valuable the report card is.

We really don't know that for health plans. We may know here is where they are on a given HEDIS measure, we have no idea, at least the stuff that I've seen, how many docs fall above that, how many fall below it. The standard deviation doesn't mean anything to --

MS. O'KANE: I think you're a generation out. It's a very, very important question.

MR. MacBAIN: But until we have that, it really doesn't tell you much.

MS. O'KANE: You're right, you're absolutely

right.

DR. O'LEARY: I think the accountabilities -- the plans should be holding the provider organizations and the physicians accountable but I think we need mechanisms for Joint Commission, AMAP and others to hold those also directly accountable and be able to provide the kind of comparative information that you're talking about.

One of the things I'm worried about through all of this is that there is already a stunning amount of comparative information available and it's not being used, couple hundred thousand hits per week notwithstanding, probably all the wrong people there for the wrong reasons.

At the same time we have an obligation to keep looking to make sure that we're providing the kind of comparative information that people really find useful and I think that while the health plan should be able to provide that information, we should be able to provide it directly as well because some people will come to us and they need to be able to go to multiple points where they can get the information they want.

DR. LANSKY: The technical answer to your question

I think is we can use the standard error of the mean of the distribution of the measure we're looking at and incorporate that in these roll-up scores I described to you, our five scores. So we do try to capture the amount of variation in performance within the units being analyzed as part of the scoring system to reflect that.

DR. WILENSKY: Bill and Hugh, if you can keep your questions very short it will help us.

DR. CURRERI: My question is directed to Dr. Smoak. I do want to congratulate the AMA because I think this is a wonderful initiative and I think it's well needed for educational purposes. But I have a single problem, and that is that if you're going to compare physician performance to some benchmark, you have to assume that all physicians have an average practice. We know that isn't true. There are some physicians that like patients with lots of comorbidities and others that shun those patients.

So without some sort of risk adjustment I don't see, myself, how you're going to be able to compare physicians to some standard. And I think that the numbers in a physician's practice are simply too small to do

adequate risk adjustment. I wondered if you'd thought about that and how you plan to deal with that problem.

DR. SMOAK: The answer is, yes, we have addressed that. I would say as an example that we do believe that we can set standards even though the physician's practice and so forth do vary -- there's variations in that. Just as we all go through residency programs, we have a board of whichever discipline we go through, and that is a set of standards that people can pass who come from a variety of different residencies and will have a variety of different experiences within that. So the answer is, yes, we've addressed it and we believe that we can do it.

In terms of the sampling, we have looked at that and it's interesting that you don't have to have 5,000 cases to be able to get a pretty good feel of where someone is in terms of their performance in that particular diagnosis or procedure. So the statisticians and all have addressed that and it can be brought down to a relatively small number within a practice that will give you, within a plus or minus of few percentage of very accurate information. So that is

something we will continue to work through in the future with our Parts 4 and 5, and I believe we will be able to address those issues very appropriately.

We will obviously pull very heavily on the specialty societies to provide that information. We're not about to say that an orthopedist ought to do this, this, and this in order to be judged as a good orthopedist, an ENT guy similar. Those specialties are going to provide that information as a core and they we will carry out the process of judgment on the basis of those standards.

DR. CURRERI: But if you as a surgeon were only getting patients that were referred to you by other surgeons because they considered them too risky to operate on, and you enjoyed that and it was challenging to you, would you feel it was right to be compared to the average practice?

DR. SMOAK: It's a little bit of a problem there, I would agree with you because raw data is always of a concern. But I suspect that if you are the Cooley's of the world in heart surgery, you're probably so good you would be above that plateau anyway.

DR. ROWE: Bill, one comment just quickly. One of

our faculty, Mark Chassen, has found this to be the case with respect to like breast surgery and heart surgery, that the number of cases that need to be -- the sample size that seems to get a reliable estimate is smaller than you would have guessed.

DR. WILENSKY: I'm going to let Joe have the last question.

DR. NEWHOUSE: Let me thank you for coming and say, I think the world is clearly better off for what you're doing. Having said that, let me bring up what I think is an issue that I know is an issue for Peggy and Dennis and I think for the other two of you as well.

Part of what you do focuses on process measures of quality of care, and inevitably you wind up with process measures that focus on certain areas or diseases or specialties more intensively than others. Then that in turn sets up incentives for whomever it is you're rating to put resources into improving their measure in those areas. I'm wondering what your thoughts are on how to deal with the set of issues that that raises.

MS. O'KANE: I think what I'm impressed with are

the systems that didn't exist that exist now because we're measuring these things. I agree with you that we'd better be careful about generalizing from what we can measure to what we can't measure at the moment. I think that as we evolve the measurement strategy, I think we're going to have to consider rotation of measures and so on, so that there is less an ability to predict and focus energy on what's being measured, so that it's a more comprehensive sweep across the system.

But I think we fail to understand very often in health care, how many systems do not exist that need to exist, and the act of measurement actually creates a systems consciousness in the health care system I believe. So, yes, it's a problem in the short run from a validity point of view, but I think in the long run we can deal with it through strategies of less predictable measures and so forth.

DR. O'LEARY: I agree it's a problem, but I don't think we should overlook the opportunity that we are looking at here. The fact of the matter is that we have relatively little understanding of why what happens, happens inside

health organizations. We're talking about health plans, hospitals. I don't care what you're talking about, we don't understand why we get bad results or why we get good results.

The art form here is going to be linking outcomes measures to the processes that contribute to those measures and understand -- learning how to manipulate those processes to optimize outcomes. If we can do that for just a few diseases for openers, we are light years ahead of any place we have ever been before.

Now I understand the problem of what gets measured, what gets done. But right now nothing is getting done in the realm of what I just talked about. And it's a challenge because, yes, we can rotate measures, but you can't rotate them too fast because you have to have a certain number of data points. You know all the problems around that. But I think you have to start somewhere. And I think there is a rich opportunity there for us to learn about organizations, systems, and processes.

DR. NEWHOUSE: Those are the answers I give my students, too.

[Laughter.]

DR. ROWE: But, Joe, why do you think it's a bad thing? In other words, if in general quality in area X is low and we decide we're going to start measuring it and punishing people if it's not good, so they put extra resources in it to make sure that the quality is better, then we're going to punish them for trying to --

DR. NEWHOUSE: See, Jack, in the economists' world there's no extra resources. You're always pulling them out of somewhere else.

DR. ROWE: But still, at least you're improving something that somebody judged to be an important dependent variable or they wouldn't be measuring it. So the world's got to be a better place --

DR. LANSKY: We have two different responses to that. One is, obviously we've emphasized outcome measures as a way of avoiding that problem, while it raises others. But the second is, we've shifted our measurement strategy toward a competencies-based approach so that for chronic illness in children, or for chronic illness in adults, there are a set of care competencies which can be measured

independent of the specific condition which is requiring that competency to be provided.

By asking patients directly whether they have knowledge of how to manage their symptoms in case of a flare-up, and so on and so forth. So we're building actually survey-based tools to do that, exactly to overcome that problem.

DR. WILENSKY: Thank you. For the benefit of some of us, we would like to encourage you to do this in the next 10 years rather than the next 20.

[Laughter.]

DR. WILENSKY: Thank you very much.

DR. ROWE: Thanks very much all of you.

DR. WILENSKY: We need to move on to our next panel, if we could have this transition quickly, please.

Beth, do you want to introduce our second panel?

MS. DOCTEUR: Our next panel focuses on the use of some of the quality assessment tools like quality measurement and accreditation findings that we were just enlightened about in our previous panel. Here we are going to hear about how employers, purchasing groups, agents for

employers and purchasers are using these types of tools to influence the quality of care that individual consumers receive.

This panel represents groups that are doing cutting edge work. They're here as case studies showing some of the innovative things that can be done and that are being done, as opposed to representing the typical purchaser at this point. So let me introduce our individual panelists.

Our first speaker will be Dr. Charles Buck who heads up the health care quality purchasing initiatives of the General Electric Company. Next will be Patricia Drury, who works with the Buyers' Health Care Action Group, a Twin Cities, Minneapolis-based health care group. Our next panelist, our final panelist will be Suzanne Mercure, a private consultant who works with employers and others on their benefits purchasing strategies and other related issues.

Again, additional biographical material is available in your meeting materials. So let me turn to Dr. Buck who's going to endeavor to do this from the overhead

projector.

DR. BUCK: I'm glad to be here. I must say, our work builds on a lot of stuff from the previous panelists and we're grateful for the work they've done. I liked Peggy's comment. I think they're sort of quasi-regulatory in format and I think provide basic protections to the public and our employers. We're hoping to push the bar beyond that level.

I wanted to talk about three things. One, the culture: where are we coming from as we think about quality, which is essentially GE's six sigma quality program. How we're actually using our $1 billion now to drive the system. And some issues we're wrestling with, because I don't think we're near where we want to be yet.

Inside the company, our chairman -- some of you may have heard of Pat Walsh, she's a bit of a lunatic about quality -- has committed the company to produce virtually defect-free products and services and transactions. We see that as a huge competitive advantage. We are immersed in quality. I say that because it's partly, as a health care net it's sort of how -- it's the context we're working in.

But we've also learned a lot about what it means to provide real excellence.

Just a little techie note. Six sigma means 3.4 mistakes per millions times you do something. That's a mind-boggling concept. Two sigma is about 30 percent errors. That's where a lot of health care systems are. But that's a techie note, so if I use those words you'll know what they mean.

Inside the company, what does this kind of commitment mean? It means everybody is focused on customers. You don't want to do things with sigma if it isn't awfully important to your customers and to your business. This is not a program. This is a way to run a company.

Matrix and data drive everything. I get a little concerned. We talk about measurements being extra cost. If we're actually measuring what we're doing to improve processes, reporting measures aren't extra cost. So it consumes the entire way a company is being organized and driven.

Now what are we doing in health care? At this

moment what we're doing is -- I'll just skip a lot of this. But we're in sort of an outsourced environment. Appropriately, we don't make our own care so we can't apply six sigma in the way that people who make jet engines do. But what we've done is we've paid a lot of attention to our customers, and CTQ is a jargon for critical quality.

We've spent a lot of time deciding what it is they really want, understanding them, focus groups and everything. We've developed a buyer's scorecard that obviously looks at that. We've updated our contracts. We measure our health plans and all of our other suppliers on these scorecards quarterly and we use that to drive our relationship with health plans.

We've done a lot of the same kind of work that Dave has done. He's much more sophisticated in it than we are, but just an interesting point. We've asked our employees a lot of questions about what makes them happy with their health plan. Right now what they tell us, it's things like customer service and delivery issues, billing on time, pay my doctor. In some ways, it's interesting, they're asking us for the kinds of things that HEDIS

measures. We wonder why they aren't asking us about these things.

I think one is, when we solve these problems they will start asking about those. And perhaps they're more wise than we are about the real role in the public plan of delivery of actual medical care.

But from that information we've got a bunch of measures, many of which we've just taken right out of NCQA and HEDIS, in these broad categories, trying to meet our customers and GE and our members' CTQs. We have put scorecards together and are measuring our plans. Thirty points on member satisfaction kinds of things, 30 points on cost measures, 30 points on a variety of other measures.

And these actually cut across employees too, and NCQA accreditation, composite HEDIS measures, eligibility errors. They not only cause us business problems, they cause our employees problems. If they go to their doctor's office and the eligibility system has failed -- so those are the broad measures we are using.

We're into this about a year and-a-half now. We've had about a 7 percent improvement from 1997 to '98 in

overall scores, and actually with improvement in all quadrants, but one that's an anomaly. But interestingly enough, speaking of variation, lots of variation in our health plans across the country. We have about 40 plans, so lots of room for improvement. These are measurements and their performance are tied into our contracts and risk rewards.

So that's what we're doing today. We think it's appropriate. We think we're doing some good stuff. But what concerns us as we look down the road, when you take a six sigma look at the world is, that there are a lot of errors out there that are probably more important for our employees and the public that we're not doing a lot about yet. This is a six sigma chart; one sigma to six sigma, and I'll just point out a couple things.

Take airline baggage handling as maybe the benchmark; IRS tax advice is another benchmark. But look where the percent of our care that we provide that's within the AHCPR low back guidelines. Flu immunizations; patients reporting difficulty with referrals; beta blockers after heart attacks. I mean, we have errors in the health care

system that most of us certainly wouldn't tolerate from other industry and even death rates are much higher in hospitals than they are in airlines, for example; at least 2,500 times.

So we're beginning to wonder about that. How can we move the discussion to those kinds of things. A concern we have is that the differences -- and this is low back care outside of the AHCPR guidelines and we see no difference between managed care and indemnity, and really not much -- well, some difference, although in the wrong direction, in 1994 and 1996 and '97. So we were wondering what this layer is providing.

I guess basically what we're wrestling with and it was raised in some of the discussions is we're measuring a lot of important stuff. It's stuff that we would act on and it's doable, but it's not stuff yet that our employees want to act on. And we're not going to get real aggressive until we're measuring things that our employees care about. We're not going to tell our employee to give up a health plan and go over here and give up your doctor, if it's not something that we think we can convince the employee that it's

important for them, too.

So we're spending a lot of time wrestling with how we can move the game to measures we know. We know that hospitals that do more than 350 bypasses are better than hospitals that do 50. Why don't our health plans tell our employees that? Some of these kinds of things about quality we know.

From a six sigma perspective, finally just let me say, we begin to raise, when you get from two sigma to three sigma to four sigma, out somewhere around five or sigma, really trying to push excellence, we wonder which kind of system can actually go to that level. What we've learned from GE in driving true excellence, it takes people working side by side and their economic lives tied together, thinking about processes, not functions, cutting across boundaries at all times, every day, all the time, measuring everything.

And it raises a question in our mind about some of the organizations that are in place now, how far they can go to true excellence. I'm talking we may now be 10 years away, but it's an issue I think from the Medicare

perspective to think about, is if I had a list of things for you not to do is don't do things that would discourage movements in the direction of true organized medical groups.

DR. WILENSKY: Thank you. Chuck, I'd never heard the quality sweet spot. I like that. I'll use that.

Pat?

MS. DRURY: I actually brought overheads, too, as did my colleague here. You see here the totems of corporate culture. We're nothing without our overheads. But I'm going to attempt to do this without them. You have hard copy.

The Buyers' Health Care Action Group is a purchasing consortium in the Twin Cities. The second slide gives you some of the names. There are just under 30 large self-insured employers, big companies that are headquartered there, 3-M, Honeywell, Cargill; some major employers. They represent over 400,000 lives. At the moment, 135,000 of those lives are involved in our purchasing program.

What I'm going to do is tell you in a split second how our program works so you have some context for the rest of it, and give you a couple of highlights of what we do to

reinforce quality in our purchasing, and then finally show you some results of how consumers are using information, because we've got at least what we think is the tip of a very interesting iceberg.

The purchasing model became effective in 1997. We've been purchasing as a group since '93, but started a new model last year, which we do not purchase from HMOs or other health plans. We are doing direct contracting with provider groups.

To give you an idea what that means, in the Twin Cities there are three HMOs that have about 85 percent of the total market. They had roughly 75 percent of the doctors were in two or even three of those systems. That has turned into a choice among 19 to 20 care delivery systems with no overlap of primary care providers. So it's a much finer-tuned choice that we offer to consumers.

All of our companies contract with all of the care systems and offer a complete menu to their employees. Benefits are identical across the care systems. Nobody is switching around with what they do or don't cover. Our employers hire an administrator to do all the moving the

money and paper around, so it doesn't create a barrier to entry. We're not turning providers into insurance companies.

On the next page, an important thing that we do is we risk adjust our payment. It's a complex payment model that I'm not going to take time to go into, but it's effect is similar to capitation without transferring insurance risk, because we are self-insured employers. But the risk adjustment, which is based on ACG technology applied retrospectively -- so it's fairly powerful -- does play an important role in supporting quality. It makes it possible for a group to get very good at serving very sick people and not be afraid of that becoming known.

Then we ultimately -- each of our employers offers all of their employees a choice among these care systems, and our consumers choose directly based on cost. They cost different things. The systems bid on a standard population, standard benefits, and we price them to the consumers according to those bids. So we have a cost sensitive group of consumers. Then we provide them what we can in the way of quality and customer service comparative information.

The next slide in there shows just a diagramatic representation of this. There's, on the left-hand side, the employer and the administrator doing all the behind-the-scenes stuff, and the actual market transaction that matters is this one between the consumers and the care delivery system which are designated by boxes here, A, B, C, D.

A major goal of our employers is to put the patients and doctors back in the middle of the market so that the key transactions are made by them and doctors, and their organizations feel accountability directly to their patients. We know this is working because we're getting feedback from doctors that when their prices go up, they hear from their patients that they don't like it. So we're getting actual patients showing up saying, do something. And they're telling their colleagues, we've got to do something, and things are happening.

Our trend is lower than the market's trend. It's lower than both commercial and state employee for the last several years.

With respect to quality, we have several things that these purchasers do. We do have some explicit

requirements for formal continuous quality improvement programs that are part of our contract with each care system, as well as having credentialing requirements; a lot of structural sorts of quality measures that we require.

We verify these through an audit program which is a customized program that's been developed for us by the joint commission. We are auditing each of these systems with respect to their quality initiatives as well as other contract compliance, and we will ultimately stop doing business with any system that consistently cannot meet our minimum standards. Our first cut will be to work for improvement, but our employers are committed to cutting people off if they cannot and will not perform according to what we think is a minimum acceptable standard.

We do offer, as I said, consumer information, and I'll go into that more in a minute. And we initiated this year a quality award which is described a little more in the next slide. Just briefly, it's based in three areas: patient satisfaction, completeness of preventive services according to age and gender, and the process measure of CQI implementation. It's about all we can do with our small

numbers across this many systems, but our employers have put some real money behind that. Our systems that win this award will receive either $100,000 or $50,000 in unrestricted cash, which they are all telling us they plan to invest in system support to help their quality improvement efforts.

The things that I think you might find interesting -- forget the summary slide for a moment on the next page -- shows you what we give to consumers now. It's a star chart similar to those you've seen, I think, from other sources. This is based on our patient survey, and it has other information here as well. The stars represent 95 percent confidence interval on the various items of whether they are above or below the average based on 95 percent confidence.

Then you'll notice that all of the care systems on the menu are divided into cost groups. So we have comparative cost information in the same visual field, which we found makes a big difference. And then this little thing that looks kind of like a squashed deer tick tells you who won the quality awards. There's a footnote that didn't show up on this page that would explain that to consumers.

The next two slides are what I wanted to be sure to be able to share with you because it was fairly exciting. The program started in '97, so open enrollment in '98 was the first time that people had to look at whether they wanted to make changes. And we had some of our companies that didn't ask their employees to pay more for the more expensive systems, and most of them did. So we did a little quick analysis of the difference in the results between those two kinds of companies. This is quick and dirty, but it's provocative.

What we show here in this chart, you'll notice we have the care systems divided into low cost, medium cost, and high cost, according to what they bid. We sorted them into the top three, the bottom three, and everybody else on satisfaction results: the number of times they had three stars, and then we looked at the percentage change in their enrollment. In the first slide, these are the people who are not cost sensitive: their employers asked them to pay the same thing no matter what. And it's kind of a random bouncing around.

In the medium cost there's one with a pretty high

percentage increase. That was the top performer in patient satisfaction. So there's a little evidence that people might have looked at it.

But then you go to the next slide, which is on the same scale, and these are the people who are cost sensitive, and the differences are huge. We see a general drift downward in cost, which is what you'd expect. People are cost sensitive and there is an elasticity of demand there. But we also see that the satisfaction results intervene in that.

In the high cost area, we had one system that was an outstanding performer and they grew and picked up members in spite of being the highest cost. Our lowest performer was also in the high cost system, and that's the one on the far right, and they lost the most members.

So what we conclude from this is that when the choice is relevant to consumers -- they actually have to think about it because they're going to have to change doctors if they change -- and they are sensitive to cost, then information on performance becomes highly relevant. And some rough and dirty survey work is showing us the same

thing, and we're pursuing some possibilities to study this in more sophisticated methods.

But we did want to share that with you because we're convinced here that when they're -- it's not just among financing plans to get to the same doctor. This is a real choice, with real money, and at least the beginnings of good performance measures, and we see consumers responding. So we did want you to be aware of that.

Let me say on behalf of our employers that we're interested in our experiment and we hope you are too, and we would be glad to share with the Commission or its staff any other findings and results that we have as you develop your proposals.

DR. WILENSKY: Thank you. Suzanne?

MS. MERCURE: Thank you. I've asked Beth to use the overheads that you have so your audience will see what I'm trying to talk about. Whoever mentioned the Alice in Wonderland, at the end of this you may decide which side of the looking glass you think I'm on because what I'd like to do is talk about the experiences I've had in multiple purchaser settings because this is iteration number nine of

my life. So that I want to use that, what I think I've learned from that, and opportunities to work with the government to apply some of that learning on things I believe that you might look at for HCFA.

The reference of the work I most recently did at Southern California is in a recent GAO report that was released within the last couple of months so any detail on that is in a GAO report already. What I want to talk about is the role of the purchaser at an individual level, a regional level and national level and then some suggestions for actions for Medicare.

As an individual purchaser, you've heard from both of the other speakers today what happens at a market level and how much influence that can have. We have not really discussed the influence back to how that changes things in a detail.

One of the things that is the involvement that employers have with their consumers and the support systems, so that means are there to help consumers through the maze and how to use the information. And also using that information for quality improvement as feedback to plans.

For Medicare it seems to me that extends also to the kinds of ways that you might look at performance goals for health and for health plans and providers. I separate the two because there are so many people in fee-for-service that it seems to me you have to look more broadly in context at this. I think that's where employers are going, really looking at the next level now.

Consumer involvement, it seems to me there are resources available through the administration on aging. There's a whole network of area agencies on aging that actually do some support now for this maze. That's a real key role that employers play for their retirees as well as their actives and also providing even more support to the beneficiary services staffing area of HCFA so that they can really more effectively have that and produce the tracking mechanisms to really help and feed that back for quality improvement.

At a regional level you've heard the Minneapolis model of how purchasers are acting together to try to influence the market and quality and really in a more collaborative way and looking at the kinds of things that

might be specific to that market. It seems to me there's a role for Medicare at the regional level to be more actively engaged with some of these initiatives. Certainly, I just moved from California, I know there's some of that going on in California but to increase that so that there could be more collaboration. Also to look at what kinds of ways we could do health education.

I frankly don't see much of a public role in health education right now and it seems to me that is something that is really needed and there are agencies in the public sector that could play a much, much bigger role in that that would help all of the purchasers, but certainly it would ultimately help the consumers. And again, data at that local level could then be turned around into quality improvement initiatives whether that was with providers, plans or actually education for consumers.

At the national level, you've heard about all the sorts of tools that the private sector employers are using. HCFA certainly is involved with those also and using some of the same initiatives but another thing is, and I'll leave this with Beth, this is hot off the press, is the Managed

Health Care Association is working with HCFA on what does Medicare+Choice mean to all of those people who are covered under retiree health plans? How can some of that learning of the private sector purchasers actually be used? So I'll leave those because this talks about some of the initiatives what employers are doing and you can look at how that might be useful for HCFA.

Another thing is I think there are a lot of resources in the government in terms of not only measurement but the use of things that are now developed. So, for example, in disease management, effectiveness and standards there are protocols, private sector purchasers say why doesn't everyone have the map for asthma?

So when there are protocols already developed that are not being used, how can we influence that to occur? Things that already exist, that have been invented, the research is there and where is the oversight for the use of that by providers? I think there are roles that some of the government agencies could play that would be very complementary in this and I know from some of my personal experience, of course, there's a great deal of interest and

some of that initiative is occurring. It seems to me you could influence more of that.

In summary, I believe that overall there needs to be a separation of regulation and quality improvement that most providers' plans are clearly afraid of having the 8,000-pound gorilla come to their site. So that the kind of inspection regulation process needs to have a wall with the quality improvement initiatives.

I know, and I'm sure everyone else here is experienced, you see a lot of warts and blemishes, and how do you approach fixing those things in a collaborative way I think becomes very significant. So I think that's very important to look at both that regulation versus quality improvement. How do you look at those and in a collaborative way?

The establishment of tracking for consumer complaints and support for problem solving is very critical. At Edison our retirees, of course, spent 20 minutes on average on phone calls. We got lots of phone calls from retirees versus actives. There's a lot of support needed and that's something that needs to be established and

funded, of course.

Again, I just want to reiterate to use all the resources that are available. It seems to me we could be a lot more effective in getting use of all of the agencies and services that now exist. Thank you.

DR. WILENSKY: Let me open it up to the commissioners.

DR. ROWE: Ms. Drury, I was interested in your comments about even high cost health care facilities actually increased their market share if they were seen as having high quality. At least there was high patient satisfaction.

Do you know whether the patient satisfaction measures that were most sensitive as predictors of success in the marketplace related to issues of amenities like cleanliness and food and decor or were they related to core health care values such as physician and nurse or the interactions with the administration? Do you know what --

MS. DRURY: The items that correlated most highly were the ones related to interaction with the physician, being listened to, being treated with respect, receiving

enough information and perceived quality. So it was the patient's perception of quality as they evaluate it in the interaction.

Things like waiting times and amenities don't correlate very highly at all with overall results. They're interesting but they're not the big ones.

DR. ROWE: Is this published, this information?

MS. DRURY: It's probably going to be but we'd be glad to send you -- we did do a press release on it and I'd be glad to send you that with some of the details.

DR. NEWHOUSE: And there's other things in the literature, very consistent.

DR. ROWE: Right, I know, but I hadn't seen this though. I'd love to see it.

MS. DRURY: I'll make that available to the staff here so you can see that.

DR. KEMPER: This is for Dr. Buck. If I understood you right, some of your plans are traditional indemnity, fee-for-service plans; is that right?

DR. BUCK: We offer an indemnity plan across the whole country and then what you saw was the managed care

plans, point-of-service plan that we pick city by city and we offer those in 40 cities.

DR. KEMPER: Do your measures include the indemnity plan as well as the --

DR. BUCK: We measure the indemnity plan and the employee satisfaction but we don't measure the -- use some of the same measures we use in scorecards because there's no -- they're not expected to be doing those things.

MS. NEWPORT: Patricia, I was interested in your slides in particular in a lot of ways. But let me understand, you are like a purchasing cooperative, are you similar in structure to something like Pacific Business Group on Health, or are you unique, as far as you know, in what you do?

MS. DRURY: We're similar to Pacific Business Group in the sense that we do a lot of the negotiating together. We are not purchasing insured products as they are, each of our employers is a self-insured employer and we actually run -- there's no commingling of funds. We actually run 27 side-by-side identical contracts, each of our companies sponsors its own plan.

MS. NEWPORT: Is that because St. Paul-Minneapolis are really an island? Does that make it easier?

MS. DRURY: No, it makes it possible for our employers to continue to be preempted under ERISA.

MS. NEWPORT: Suzanne, you're a consulting group that helps Edison with their decisions; is that correct? I'm just trying to understand where --

MS. MERCURE: I've recently moved to D.C. I was asked to leave California I'm sure by your plan among others. So that I --

MS. NEWPORT: I disassociate myself from any action on their part.

MS. MERCURE: It wasn't you personally. I've always worked in the purchaser role, either directly for an employer or else in the consulting realm. Right now I'm actually working on some other initiatives, for example, with the Institute for Health Policy Solutions.

So collectively with purchasers and asking organizations like AHP to work with organizations like Managed Healthcare Association to establish a dialogue that will help really frame some of the issues that we're not

addressing in a positive way before they happen.

MS. NEWPORT: In all due deference to somebody's poor decision to ask you to leave the state, you're invited back anytime you want.

MS. MERCURE: Thank you.

DR. MYERS: I'd like to ask all three of the esteemed panel members to comment on the issue of quality with respect to unions. General Electric I think has a number of different union organizations with whom it works and the six sigma initiatives obviously are initiatives that they are aware of and have been involved in certainly in the Minneapolis, Twin Cities area. There are a number of unions that are in the coalition and they are obviously concerned about these issues and I'd imagine that Southern California Edison is a unionized environment as well.

How have they reacted; positive, negative, neutral? Could you comment on that, please?

MS. MERCURE: We actually had at least every other month meetings with the union leadership. We also had consumer committees and I made sure to get union members on the active consumer committee because there was not always a

direct correlation with the leadership and the member thought process.

DR. MYERS: Specifically, if there's any information regarding the retired members of the union, because clearly the retirees with respect to our task are the folks that we're the most concerned about.

MS. MERCURE: For Edison, once someone retired they were out of the scope of the union so that --

DR. MYERS: There's no post-retirement benefits?

MS. MERCURE: There is post-retirement, but it wasn't controlled by the union as far as what happened only at that moment when they retired but let me answer in a more general way. Through all of the initiatives we did, and sharing the measures and the information, the unions agreed to freeze enrollment in poor performing plans.

MS. DRURY: With respect to the Buyers' Health Care Action Group, we have both unionized and non-unionized companies and they're all over the map. We have some companies who have chosen to offer the program only to non-union employees. The major issue there has been benefit design.

Remember, we do a standard benefit and if that's not what they negotiated, right now they're stuck. But we, at their request, and sometimes at the request of their unions, we will be offering some flexibility and benefit design to allow the unionized companies to move into their unionized populations. And at least in a couple of cases that's viewed very positively by union leadership.

The thing that's attractive in this program is they get a broad choice, nobody forces them to change doctors. They do it if they want to and if they don't want to and are willing to pay the price not to, they have that option. That has been viewed very attractively.

The third thing I'd tell you, an associate member of ours is the state of Minnesota, Department of Employee Relations, the state employees, they do all of their healthcare decision-making through a joint labor-management committee. They are carefully examining this model and may move to something very similar and that's basically led by the unions. The unions saw a presentation on this and asked the state to get more serious about the model. They liked that for the reasons I mentioned.

DR. BUCK: Our employees all have a fairly rich indemnity plan as a basic plan which is negotiated and our managed care has been well accepted by the employees. We have over 70 percent of the people. It's a positive incentive to go there but they can always go back to the indemnity plan if they want to. In general, we really -- the usual triennial negotiations over benefits which is suggested, which of course, is an economic decision that raises tensions but in terms of these kind of issues we're talking about here, that hasn't been a major issue.

MS. MERCURE: May I just add one thing? It's almost for the retiree population even though they were not members of the union once they retired from employment at Edison, it was almost like working with another union because of the retirees wanting to get into class action suits for anything that the company would do. So that it was as, I would say, you had eggshell walking as closely as if you were dealing with the union.

DR. NEWHOUSE: I also wanted to focus on the retiree side, any or all of you, what do you think the leading practices in the country are with respect to quality

among your retiree population? Do your own companies focus, do you distinguish the retirees from the actives?

DR. BUCK: Well, we don't for under-65 retirees.

DR. NEWHOUSE: And how about over 65?

DR. BUCK: Over 65 we do because they have essentially a different plan. They go onto Medicare. We have some supplemental coverage so our relationship is different.

DR. NEWHOUSE: I agree, I mean that's really the basis of the question. And that is presumably the typical case so what, if anything --

DR. BUCK: Hopefully, we are preparing them to be good shoppers, that when you all take them over and present them with the same kind of choices, they'll be ready for you.

MS. DRURY: Unfortunately, our companies have not carried this program into the retiree population as yet. It was mostly a matter of one thing at a time and there was a different set of communication issues there and they wanted to wait a couple of years before tackling that. A number of companies have expressed interest in taking this to their

retiree population and they expect to do so but we just -- it does require a whole new strategy of communication and that probably won't happen for a couple of years.

MS. MERCURE: At Edison we had a separate communication channel for the retirees, and we actually had a retiree consumer committee to constantly give input and feedback and that, of course, changed the direction of the education.

But another initiative we started was to actually engage more directly with the consumer by asking them questions about their health status that would allow us to risk stratify and follow-up with patient advocacy and care management systems because we felt the system totally failed on outreach and follow-up for people with chronic conditions and that that was much more prevalent in our senior population, many of whom felt they managed their own care and the physician would have no idea of how many prescriptions they were taking, just a total breakdown of the system and somewhat to do with trust.

MS. ROSENBLATT: Patricia, I'm extremely interested in risk adjustment and the relationship between

risk adjustment and quality. The goal of risk adjustment is often stated yet whether it's a health plan or a provider group, we want quality to be the determinant, not the fact of the ability to select the best risks. Is it too early to make a comment about how the risk adjustment system that you put in is working?

MS. DRURY: It's a little early, although it appears to be working well. One of the things we discovered is to the point that was made on the last panel, the variation within an HMO's panel in the risk distribution as well as every other measure you can think of was enormous. As we got down to these care systems, they're quite distinct and it took about six months to get some of the bugs out where people felt that they were being treated fairly, that their populations were being assessed accurately and the adjustments to their fees were appropriate, but they're now fairly confident in that.

One of the things we see is that both in advertising and in their bidding practices, they're evidencing confidence in our payment model. They wouldn't risk doing what they're doing if they thought they might get

a sick population and not be compensated for it. So we're seeing some confidence now in the provider community.

DR. WILENSKY: Anything further?

Thank you very much.

Let me have an organizational question and then we'll do a five-minute break before we start. I want to try to get an understanding about how we're going to handle the morning, afternoon tomorrow so we can make sure we have some agreement and then we'll take a five-minute break.

What we have agreed to try to accommodate both Jack and Ted who we really wanted to have, who both wanted to be here and when we have such strong interest on commissioners we hate to disappoint them that we were going to try to balance Ted's schedule of not being available in the morning because we had told them the GME would be in the afternoon. And Jack needs to get back up to New York -- to start around 11:30 or 11:45 to have our hour, hour-and-a-quarter, go around 11:30 or 11:45 to 1:00. The question that I am left with as chair is what exactly do we do between 10:30 and 11:30?

DR. ROSS: What if we instead start at 9:00 here.

Joe, you had some issues that you wanted to take up in executive session. Suppose we go into executive session 8:30 to 9:00, run this then from 9:00 to 11:00.

DR. ROWE: How about we cancel our working dinner and have a working breakfast and then move the case mix meeting up?

DR. WILENSKY: I'm trying to see how difficult.

DR. ROWE: Is that all right with you?

DR. LEWERS: Yes.

DR. WILENSKY: As a tentative proposal let's try this out and see how we use 8:30 to 9:00 for executive session tomorrow. We'll use 9:00 to 11:00 for the case mix classifications and post acute. We'll have our public comment period and then we'll start about 11:30 for GME, go to 12:45 then do a lunch break and start risk adjustment thereafter. We may have a five or 10-minute break.

DR. CURRERI: What's the possibility of having a shorter lunch break?

DR. WILENSKY: We will be having a shorter lunch break. If we don't, if we go to 1:00 and have a -- I mean we're going to have to have a shorter lunch break because I

don't think we want to move back from 1:30. We want to keep risk adjustment no later than 1:30 to 3:00 so we will, if it means a half-hour lunch break, that's what we'll do.

DR. ROWE: We apologize for shortening the lunch break.

DR. WILENSKY: As we've indicated, any future changes that occur we will have cleared via e-mail before the meeting starts. So it's as much our concern that we not misled the public who plans to come to hear certain presentations as that we disrupt the commissioners' schedule. So we'll try and make sure that from now on any changes get cleared up and then we can at least make them publicly available before we start.

So if that's okay, why don't we take a five-minute break before we go into the next session?

[Recess.]

DR. WILENSKY: Thank you very much, Bob and Jeff, for coming. We know you have many demands on your time with all of the changes that are being implemented as a result of BBA, to say nothing of the Y2K issues. For those of you didn't notice, there is a button on Bob Berenson's lapel to

show you it's never very far from his heart, but not mine. We are grateful to your willingness to share the kinds of strategies with regard to quality assurance that Medicare is considering and adopting.

As you can see by our schedule we've been focusing on what the various tools for quality assessment are and what some of the private sector companies have been doing to try to make use of the tools but ultimately our interests are how this can be most usefully applied to Medicare. That's obviously your concern and so thank you for sharing some time. Bob, or whichever of you want to start.

DR. KANG: I guess I'm youngest so I get to go first.

DR. BERENSON: Jeff is the quality czar, I just carry his bag.

DR. KANG: I'm going to try to keep this quite short. I appreciate the opportunity actually to present to the Commission and this may be a little repetitious because I presented variations of this elsewhere but please bear with me. I'm going to talk a little bit about HCFA's performance measurement strategy and QI, quality improvement

strategy.

I'm going to also talk about how we're approaching this both in managed care and fee-for-service. Then Bob is going to talk a little bit about the consumer protection issues and the issue of about paying for value or paying for better quality. That's how we're going to split this up.

This overhead is actually a quality improvement diagram and a performance measurement diagram that we're using at the Health Care Financing Administration. You all have this in your handouts. This was actually adopted under Administrator Vladeck and re-ratified under Administrator Nancy-Ann Min DeParle.

In a nutshell, let me just run down this quickly, quality improvement and quality assurance in HCFA's view begins with actual performance measurement and the performance measurement of either clinical processes or outcomes. I would actually broadly define patient satisfaction as an outcome that we're very interested in, in the healthcare system and you've probably heard other speakers speak to this issue. It starts though through setting priorities and this is really with HCFA and Medicaid

state agencies as purchasers.

We do have to adopt the performance measures, which is the fourth box down, collecting, then we have to collect the data, and then we have to analyze the data and identify opportunities to improve. I think the most important line on this chart really is the bottom line, which are really the interventions based on data that HCFA could conceivably do as we try to move towards the value based purchaser.

The first here really is establishing and enforcing performance standards. This is the idea of actually, as a regulator we want to establish minimum performance levels, and I'll come back to this issue.

The second is based on performance measurement and identifying opportunities to improve is that we ought to invest in an infrastructure, quality improvement infrastructure to actually improve the care. And I'll come back to that issue. That really is the peer review organizations, or now called quality improvement organizations, but that's going to be HCFA's mechanism for actually investing in a quality improvement infrastructure.

The third issue is giving consumers a choice, information with regard to quality providers and plans and I'm sure the Commission knows very, very well this notion of trying to change competition around just dollars and cost to actually add competition around quality to this. I think the missing element here is actually performance measures that are either plan specific or provider specific. That's part of the strategy here.

The fourth issue is based on quality information, we ought to be making coverage decisions which actually promote quality. I'm not going to spend as much time on that issue. Then the last, which Bob will talk a little bit more about is this notion of to the extent that we can measure performance, can we actually pay for value or does the market care about value.

Now this is actually a summary slide of all the performance measurement systems that we have going on here and I'll just walk through just some of the highlights. For managed care organizations, you've heard from Peg O'Kane today. We have HEDIS, this is required now for HMOs. There's also this health of seniors measure, which is an

outcomes measure which looks at the quality of life or function of status of the Medicare beneficiary. This actually is a managed care, Medicare managed care requirement.

Then the last, which is also a Medicare managed care requirement is the CAHPS member satisfaction survey. So we're actually in quite good shape here in managed care organizations. We are in the process of collecting these performance measures and we actually hope to soon release the 1996 HEDIS data to the public. With regard to hospital providers here we actually there are measurement systems that we've developed for the PRO program and I'll come back to that.

And then as you probably heard today JCAHO is trying to create this ORYX system here. Now, none of these are actually required as a Medicare condition of participation, and I'll come back to this issue, but at least there's some development of performance measures for hospitals.

For nursing homes we are in a much better situation. Our nursing home situation is based on MDS or

the minimum data set. All nursing home providers are required to collect this. We are in the process of creating a software package called RAVEN which would allow the universal collection and analysis of the minimum data set and then conversion to a variety of quality indicators out of the minimum data set. This would be for all nursing homes in the country and all nursing home residents.

Home health agencies similarly were in the process of requiring OASIS, an outcomes measurement system developed by Pete Shaughnessy in Colorado, and then again there's a similar collection tool called HAVEN, which we intend to make that software available free for the purposes of a standardized collection of this performance measurement for home health.

Then the last thing I do want to mention is physicians, fee-for service physicians here. We're beginning to look at the application of HEDIS measures in fee-for-service. We actually have a contract with HER or Health Economics Research to pilot the use of this. And the unit of analysis were positions that we're starting off with is the group practice. We're looking at physician group

practices and asking what their HEDIS performance measure is and we need to actually look at kind of how we need to modify those measures somewhat so we can actually use them in fee-for-service.

What I really wanted to describe was for HCFA to begin to make this jump from a bill payer to value based purchaser, and measure of quality, there are three key requirements that we need to do. It's important for me to put these up there. These are actually in Medicare+Choice and are going to be further explained or implemented in this QISMC or Quality Improvement Standards for Managed Care, which is being released either today or tomorrow, I'm not sure exactly the correct timing. But we do have these three key requirements for Medicare managed care.

What we are in the process of doing is trying to move these same three key requirements into the various conditions of participation in Medicare fee-for-service so condition of participation is for hospitals, nursing homes, home health agencies, et cetera. The three key requirements when you think about this are a requirement to collect and report on standardized performance measures, and I've

broadly defined this as clinical and satisfaction outcome processes.

Then a requirement based on those standardized performance measures for those providers to then meet minimum performance levels.

Then the last is based on those performance measures for those providers that have a requirement to actually show performance improvement and we actually have these requirements in Medicare+Choice, and like I say we're in the process of moving these too, the same similar requirements to providers.

Now, with regard to the PRO program here I really need to talk a little bit, because I've mentioned the PRO program as the public kind of infrastructure for quality improvement. Right now the statutory mandate is for individual case review, that will continue and we'll really use that individual case review for sentinel events and the assessment for fraud and abuse.

In the fourth and fifth scope of work, we had quality improvement programs but they were voluntary programs and they were actually just state based. So in

other words, you had 50 PROs out there creating 50 state-based improvement projects and they were all over the map. A lot of activity going on but we actually had very little to show. There were a lot of successes but they were all at the state level. Now, where we're headed in the sixth scope of work, which is going to go into effect April of '99 --

MR. SHEA: What's a scope of work?

DR. KANG: It's really our term for the contracts. We write three-year contracts. This is basically what's going to be in the three year contract. We now are going to move this instead of through these local projects to six national quality improvement areas. When we nationalize this, what will happen is that we will insist on a standardized measurement system for each of these projects here.

So for example, for acute myocardial infarction, we will insist on a standardized measurement system for the use of beta blockers, ace inhibitors, time to reperfusion, et cetera. Now, we'll do this with all PROs in all 50 states and I think that that, beginning with quality improvement and will begin to help address the

infrastructure issues, for then subsequently collecting performance data for the purposes of publishing.

But I actually think that the first step here is actually to begin this in this setting with fee-for-service as quality improvement exercise. I'm sure as you all aware of is to the extent that we kind of learned this lesson from HCFA, the mortality data is that when we published the mortality data and the public sees this simultaneously as the providers, the provider's first instinct is to attack the data. There's something wrong with the data.

I actually think there's an intermediate step before publishing performance measures where you actually work with the providers on quality improvement projects so they can get used to the data, what it means and also understand how they can improve the quality. And then the next step is then based on whether that data is accurate, does it actually go forward and publish this as a plan or provider's specific profiles.

DR. ROWE: Jeff, is that community acquired pneumonia?

DR. KANG: It is community acquired pneumonia.

And maybe I should just take an opportunity, in that pneumonia category, three or four processes that we'll look at. We'll look at time to antibiotics so there's -- and what we've discovered in hospitals is a lot of times there's significant delay in the use of antibiotics.

The second is appropriate use of antibiotics.

The third thing we'll actually look at pneumonia vaccinations, pneumococcal vaccinations, flu vaccines. So in that pneumonia project are multiple processes that we're interested in that we'll all kind of conspire to improve mortality rates. And I'll come back to this issue in a little bit just to --

DR. KEMPER: Can you just clarify what unit does this apply to?

DR. KANG: The unit of accountability? The unit of accountability for us with the PROs is the state because each state -- now, my guess though is when the state thinks about -- when the PRO in the state thinks about this is that they will begin to move towards provider profiling, and I'll come back to this issue is because they need to assign some accountability within their state.

This actually is -- I'm going to use beta blockers as an example here, this is the beta blocker use and managed care from 1996 HEDIS data. Reasonable, normal distribution. Lots of opportunity to improve. And I think that's -- if I can have the next overhead?

Now this is actually from the CCP, this is actually all hospitals in the country, 1,990 who have significant myocardial infarctions, all their heart attacks. So this is 1,990 hospitals in the country and this is the baseline beta blocker results from hospital performance. As you can see, plenty of opportunity to improve normal distribution. I think when faced with this kind of distribution, people think we ought to set a minimum and then we ought to set incentives to actually move that distribution to the right and narrow the distribution and performance.

Now I intentionally did not compare this with managed care because these measures aren't comparable, they're not standardized. There are some subtle differences in terms of how we're doing this in fee-for-service versus managed care.

Actually, we missed a major opportunity here in that these are actually all the heart attacks occurring in the Medicare population. We only asked, we started off with the question of what's the hospital; the hospital has the unit of accountability. We missed an opportunity of asking, who was the attending physician? Or who was the payor? Or we do actually have the state information so I can give you a distribution kind of a regional, a Jack Wennberg-kind of like state, what's the state distribution here. But we did miss an opportunity and I wanted to come, because this is very important to the extent that we begin to move standardized information sets in managed care and fee-for-service.

The realities of what we're talking about is an information set that is centered on the beneficiary because the beneficiary and his or her event is the same, irrespective of delivery of service, who's delivering it, or who's the payor and that what we're really arguing about is different units of accountability or analysis but the event is the same.

I think to the extent that we in these six part

improvement projects can move in that direction and create the national infrastructure to that. We will end up being able to generate information for whatever unit of accountability we're interested in, whether it's the state, the hospital, the doctor, or the payor. And by the way, under HIPA the unique identifiers that we need for states, hospital -- I mean not for states but payers and doctors and hospitals, it's going to be very important for this.

Just to talk a little bit about what data can do to help us here, this is actually a same CCP project, myocardial infarction, and answer Jack, these are the seven or eight PRO process measures we looked at. These are four states now and as you can tell we were able to show just through feedback, giving the hospitals their profiles and then feeding back, they actually improved their performance on all of these process measures.

And the bottom line, it resulted in a 3 percent reduction in mortality after heart attack, a one-year mortality rate and it actually, this was statistically significant above the secular trends here.

So this is the power of beginning to profile

providers and give them information, compared with their peers so that they can actually improve. So what we're trying to -- we accomplished this in four states, the PRO program. We're actually going to try to move this nationwide.

DR. ROWE: Is this single shot feedback?

DR. KANG: This is single shot feedback.

DR. NEWHOUSE: Is this against the control group of the other states?

DR. KANG: It's against a control group. These are statistically significant --

MR. SHEA: This is four states?

DR. KANG: This is four states, nationwide.

DR. MYERS: Which four?

DR. KANG: I don't know. Is someone from the PRO program here? Connecticut is one.

VOICE: Wisconsin, Iowa, Alabama, and Connecticut.

DR. KANG: But these are four states and what we want to do is move this nationwide. And to the extent that we move this nationwide it's -- unfortunately, we've already done the baseline collection. But that's what I mean, it's

a missed opportunity because we should have asked what the attending physician of record was and what the payor was, because then you could have cut this data by those different units of analysis.

DR. ROWE: Did you know, since obviously there's variability with respect to people adopting some of these practices and not others, was the adoption of some of them a better predictor of this reduction in the mortality rate than others?

DR. KANG: Yes, the answer -- the better performance on these processes were correlated with better mortality, reduced mortalities.

DR. WILENSKY: Which ones?

DR. ROWE: Which behaviors?

DR. WILENSKY: Presumably, some of those may have been more --

DR. KANG: Were more predictive? I'd have to get back to you.

DR. ROWE: Okay.

DR. KANG: We did do that analysis and I can't recall which was --

DR. ROWE: That would be interesting.

DR. KANG: That's more of the -- but yes, we should be able to get that data and it has been done. It actually may, in fact, be in the JAMA article that we published on this last May. I'd be happy to get a copy of that article.

I'm going to stop there in the interest of time because I have a fair amount of summary slides but they're really going to get into kind of the questions and answers. I don't know if you want to take more questions?

DR. WILENSKY: Bob, do you want to --

DR. BERENSON: I think I should go and then we should open it up. I'm going to take maybe seven to 10 minutes. I have some overheads as well. I'll pass these around. I'm going to approach this from the point of view of the head of the Center for Health Plans and Providers and figure out how we can be a value purchaser. We have jurisdiction in our center now after the reorganization both for fee-for-service payments to providers as well as contracting to health plans.

As Jeff pointed out we are trying to do value

based purchasing in both sides to the extent we can but I wanted to start first with barriers. In fact, I'm going to borrow the first couple of overheads from the National Academy of Social Insurance Report on fee-for-service improvements to Medicare which identify some of the barriers that we have to confront. Most of this is on the fee-for-service side but some of it applies to the Medicare+Choice side as well.

On the fee-for-service side, HCFA is required to administer the program through third parties and, in fact, were even limited on which third parties we can contract with. That relates HCFA to much more of an oversight role rather than anything that involves direct interaction with providers. Because of that requirement we focus on policy uniformity from a fairly distant level from the providers.

We are still rooted I would say in the original deal that created Medicare not to interfere in the practice of medicine. We have limited ability or no ability really to selectively contract. There's the statutory right for beneficiaries to use any qualified provider willing to treat the beneficiary.

The other day I was actually at a meeting with the Inspector General's office talking about fraud issues and the issue was do private payers do a better job of detecting fraud than the federal government does? One of the conclusions we came to is that they don't have to call it fraud, they can just decide that's somebody they don't want to have to contract with anymore, they don't have to go through the due process requirements and get to the threshold of what we have to do in trying to identify fraud and terminate somebody from the program. We can't do that unless we go through many administrative hurdles.

There are other legal barriers and restrictions. There's the congressional limits on our administrative discretion. We pretty much work within statutory constraints on what we can do. We also work within procedural requirements.

The Administrative Procedures Act is a good example. Procurement roles and policies are very prescriptive and do not allow us to move quickly. There are limits on our demonstration waiver authority. We can demonstrate success and still need to go back before we can

implement that widely in the program. Our decision-making needs to be very transparent, and today there's an all day meeting of our risk adjustment roll-out in which the clients will have an opportunity to comment, that's a good idea but every element of what we are going to propose is subject to comment and we have to defend everything we do.

There are other considerations. The size and dominance of fee-for-service Medicare can truly effect markets, can effect providers.

It introduces sort of externalities to what a private purchaser might have to do when it is purchasing in terms of the effects. There are political interventions that we don't have to talk more about. There is slowness in decision-making. I've been impressed by that in my five months. Physical considerations and budget neutrality, I guess I call that -- we have difficulty being allowed to invest in order to save. Everything has to sort of be justified in many situations in terms of a narrow time frame and there are public goods, clearly as a public agency responsive to more than simply being a purchaser.

We support things like graduate medical education.

We try to support a rural health care infrastructure which again private purchasers don't have to worry about. So within those constraints I'd say there are some strategies that have some promise and I'm going to go over from a slightly different perspective some of what Jeff has already talked about.

I think one of the strategies is capitation and contracting with organizations as a sort of basic strategy in improving quality for beneficiaries. By capitation we are basically shifting the financial control to an organization who we contract with and it gets to make many of the decisions that we have more difficulty making in terms of trying to improve quality, whether it does improve quality depends on some of the measures that we need to sort of develop and publicize and give to beneficiaries.

I would point out that this sort of theory about decentralizing decision-making is going to undergo a very interesting test as a result of the Grahalfa decision which I don't know if people have followed. It was the Grahalfa versus Shalala, the beneficiary claiming that her appeal rights were inadequate for denial of services.

Just last month the panel of the Ninth Circuit reaffirmed the district court decision since the original decision we have new appeal rights which have moved substantially in the direction that the court wanted us to do. They're codified in the Medicare+Choice regs, but the reasoning of the court was that Medicare contractors, the HMOs with which a contract essentially represents state action, there are actually government actors and they invoked the due process clause of the Constitution as a way of justifying the decision.

So the question is whether sort of the constitutional question is whether, in fact, the private health plans are, in fact, private or whether they have to follow very strictly public requirements for due process, et cetera.

DR. WILENSKY: Will that be appealed?

DR. BERENSON: The Department and the Administration is making a decision right now. We have to -- by the 28th of September we have to make a decision and we will see. I don't at this moment wish to speak for the Administration. Those of us in HCFA who are trying to help

administer the program and see the concern about that decision, if it stands.

DR. WILENSKY: Did the circuit court indicate why 14 days was bad but five days was good?

DR. BERENSON: I don't know that specifically. There were a set of remedies in there that are problematic but I mean clearly there were some problems. The point I'm making is we're not arguing over the remedies right now, we're sort of arguing over the basis of the court decision about state action and some implications for appeal rights and fee-for-service and elsewhere.

The second general strategy is information for decision-makers and we call it decision-makers because decision-makers include beneficiaries who make choices of their providers or whether to pick a Medicare choice plan for where they should get their insurance but as I'll point out on a slide in a moment, also information for providers to make decisions for plans, et cetera. And the major activity we're doing on the fee-for-service side are demonstrations that sort of capture the notion of value based purchasing, and I'll get to those in a few moments.

The first category, capitation and contracting, which I think is together decentralizes decision making. There's a form of accountability at least in organizations that we, as Jeff I guess can point out, it's easier to come up with a measure on a number of quality measures around an organization than it is around 600,000 physicians and 6,000 hospitals. There's an organization, whether it's the relevant level of organization is subject to discussion but there is accountability.

We can, through contract as a value purchaser include quality protections and other protections as just a matter, these are the rules. If you want to play by the rules, here's what you have to meet. We don't have that ability to do that nearly as well on the fee-for-service side. And there is the potential even for selective contracting here.

We now under the Balanced Budget Act and again in our regs have to affirmatively renew contracts of our contractors. There are new grounds for terminations. If health plans do not meet requirements, again for some of the other barriers I mentioned there's a political dynamic here

but we do at least have theoretically the ability to selectively contract, which I think is one of the hallmarks of a value purchaser.

Right now, we're still paying based on uniform payment policies, a formula that's well-defined in law that's being critiqued right now by many of the health plans that don't feel that payment is adequate in a number of areas. We are en route to hoping to get a couple of new demonstrations in competitive pricing that will be more successful than the previous attempts.

Specifically, one of the areas in our discussions, and we're having a public meeting next week for two days that will really put a lot of the substance into this demonstration. But there's serious talk about having a pool of funds available for quality performance in the demonstration. The last box on the right that Jeff had pointed out, an ability to in fact reward quality in very specific ways based on achieving defined performance measures.

The next overhead, just to give some examples because we have contracts with organizations we can, the law

and our regs can define certain activities we want organizations to perform and in the quality area we've said that plans must conduct baseline health assessments for all new beneficiaries within 90 days, that plans must have procedures to identify and assess enrollees with serious conditions. Emergency services are now defined by the prudent layperson rule in statute.

On the next slide we require direct access to a woman's health specialist within the network for routine and preventive care. We have requirements which are in the QSMIC standards and guidelines on access and availability of providers, credentialing requirements that go to the confidence of providers.

In other words, we can through contract as a purchaser set out requirements and see who wants to play. Information I think will be increasingly important and will help beneficiaries choose plans, provide ability to monitor providers and allows plans and providers to monitor and improve their own quality. Jeff laid out how we plan to do that at a number of levels. Certainly, we have emphasized the information campaign for Medicare+Choice selections by

consumers, but there is certainly no reason as we begin to develop more indicators of quality that the same information would not be available for consumers on the fee-for-service side.

We would see that as something we can do without new authority in terms of selective contracting. One of our demos, the Centers of Excellence demonstration where we would set up cardiovascular and orthopedic demonstrations the contracts would go to specific entities. We can't exclude other providers who provide those services but we can certainly make available to beneficiaries the bases for which we selected those particular facilities. And again over time, have reportable data about performance so that on the fee-for-service side also choices can be made.

We have a number of fee-for-service demonstration initiatives which will somewhat be held up because of Y2K problems. These were just a number of them come directly out of the Balanced Budget Act and will be delayed somewhat but these are examples, discounted prices for bundled services, provider supplier standards for participation, case management for chronically ill. We're attempting

selective contracting and competitive bidding, it is a specific demonstration authority around DME contracting and potential to reward excellence in clinical management. And let me just sort of go through these real quickly.

The Medicare provider partnership demonstration provides a discounted DRG specific lump sum payment for all Medicare admissions to an organization that's equivalent to a PHO, except for in our fee-for-service demonstration it doesn't have to be licensed by the state as a risk taker, we essentially convert our DRG payments to this combined organization of hospital and affiliated physicians and essentially it requires the organizations to have the equivalent of an integrated delivery system but permits us to pay on a bundled fee-for-service basis. Presumably, that organization on the commercial side can be well positioned to get capitation contracts.

DR. ROWE: What do you pay? What percent of the AAPCC?

DR. BERENSON: We pay now -- this is not an AAPCC. We would be a DRG conversion. We basically lump DRG and RBRVS payments to physicians into a new lump sum.

DR. KANG: For an episode?

DR. BERENSON: For an episode. So it is not related to the AAPCC. Now, that's going to be held up because of Y2K. There is a lot of interest. This is actually targeted to New York, New Jersey, Pennsylvania organizations.

DR. ROWE: Is there a standard discount, like 75 percent?

DR. KANG: I don't know exactly what the discount is. I think there's a few percentage off of -- it's not 75 percent, it will be much higher, closer to 100 percent. I think it's on the order of 3 percent to 4 percent discount. I can get that back to you.

DR. NEWHOUSE: The incentive to give you the discount is to make it up on the Part B side?

DR. CURRERI: Part B is discounted, too.

DR. NEWHOUSE: Yes, but the Q on the Part B side.

DR. BERENSON: Yes, it's make it up in quantity. It basically, in a fee-for-service context tries to move towards sort of a capitated notion without formally being capitation. In the Centers of Excellence demo, which comes

out of the CABG demo, again a negotiated bundle payment for selected cardiovascular and orthopedic procedures, basically surgical procedures and hips and knees, and again we can designate institutions who are centers of excellence, we can't exclude others from also participating. What one of the attractions to an institution would be able to get the reputation and be able to --

DR. WILENSKY: Did you say you can or you cannot exclude?

DR. BERENSON: We cannot exclude. The institution gets to promote itself as a center of excellence. Again over time as data on performance becomes apparent as we educate beneficiaries about differences in quality performance there may be an advantage there.

Group Specific Volume Performance Standards, the GVPS, is a global budget for Parts A and B based on projected total Medicare utilization for patients seen by a provider group. This goes to a multi-specialty group practice is the probable recipient of one of these kinds of grants. Sites compete for status based on care management strategies and capacity for data driven decision making.

In this case, if based on projections of costs for Part A and Part B if the organization comes in under projection, HCFA and the organization share in the savings, there's no downside risk. Ultimately, we can stop contracting with an organization that does not hit its target.

We're beginning coordinated care demos. There's a lot of interest in this new CHF, diabetes case management demonstration, a number of applicants that we're reviewing right now.

Finally, selective contracting including competitive bidding demonstration in DME. It's starting in Lakeland, Florida. It's basically to set prices based on market conditions rather than administrative prices. It's the same sort of concept in competitive pricing for managed care organizations. We can require bidders to meet and maintain new quality standards. We can avoid business with fraudulent suppliers. We do not have to contract with every supplier in town. Right now there's an extensive provider and beneficiary outreach going on.

I guess one point I would make is it is very staff

resource intensive. This kind of process, part of it would be maybe a one time activity related to just overcoming some of the political opposition but some of these demos, it's hard to imagine us rolling it out nationally given our restraints and requirements, the staff and other requirements to pull these things off.

Actually my last overhead is to just summarize, the demos were often limited by budget neutrality requirements. Again, we can invest in order to save, that's one of the constraints we're going to have in competitive pricing. We're not able to redo the current maldistribution in AAPCC payments. We have to be budget neutral. We lack authority to mainstream these demos. We have a limited time frame to show what we're going to show and it's very resource intensive.

With that, let's open it up to discussion.

DR. WILENSKY: That doesn't get into political constraints.

MS. NEWPORT: I'm going to forgo what I -- I have plenty of time to talk to these gentlemen but I'm going to ask you hopefully a different type of question. As

clinicians and working in the quality area, what would you look to in terms of measurement of your performance? What would be of most value to you and your patients?

DR. KANG: I'm going to have to shift hats now. It's been about two or three years. It's interesting, I'm going to answer that at two levels.

One is, first of all just to get a provider profile on me back is extremely useful. I must admit I have yet to meet a doctor, including myself, that did not think that they were two standard deviations above the norm. I mean basically everyone, and the issue for me is not do I know I should prescribe a beta blocker. I mean it's not a knowledge deficit. The issue is whether I am or not. So I think just provider profiles of some sort are extremely helpful for me and my practice.

MS. NEWPORT: As a context for my question, we talked earlier about what the message needs to be to the ultimate user of the services, and I don't know the answer to that. I'm just trying to inform myself on that. So, Bob, I don't know if you have any comments?

DR. BERENSON: I guess it depends a lot on what

kind of physician. As a primary care physician, primary internist, I think it would be very useful in some kind of objective way to have patient surveys of performance, the simple things that we all make mistakes, not listening, not permitting enough time for talking, just sort of I think that kind of feedback would be very useful on an operational structured basis.

Another thing which I'm not exactly sure how you operationalize it but physicians don't spend enough time providing feedback to each other about their performance. My hunch is that specialists who I'm referring patients to could in a much more formal way be providing me feedback about my own performance. I'm not sure that necessarily becomes public information but if I were in an organization and had some ability to structure something like that, I think that would be very useful.

DR. KANG: Just the second level, Janet, that I was going to respond to was I just think from a profession standpoint that as a practice physician I feel like I'm kind of in a cost conscious era and there's just discounted fees. I think that the only way of getting the value issue on the

table is to actually show my performance and show that there's a difference in performance between myself and him or whatever. And then perhaps maybe the market will begin to say, well, maybe we ought to be paying Jeff Kang more than Bob, whatever it is.

But I just think that as just kind of advancing the profession itself in the long run, I'm willing to actually put my performance up.

DR. BERENSON: I think some of the modifications of -- the first generation of primary care capitation payments, physicians was here's your lump sum minus 20 percent we're going to hold back. I think there's much more sophistication and actually giving, reducing the base payment. But then providing positive incentives for certain performance, whether that's having more accessible hours, hitting immunization targets, getting positive renewals from your patients. I mean I think there's a number of things like that at the margin I think that are useful.

I'm not sure that the core payment should be necessarily based on performance because we can't risk adjust well enough but I think marginal payments based on

rewarding quality and other quality related activities I think does make sense and physicians respond to that.

DR. NEWHOUSE: This is a question about your last comment on being limited by budget neutrality. As you know, we report to the Congress and some of the experiences I've had with the limitations you're referring to, the limitation seems to be the Office of Management and Budget interpretation of budget neutrality. So my question is to what degree is this a congressional issue and what degree is it an executive branch issue?

DR. BERENSON: I think that's a fair question and I actually just sort of understood this as I was preparing for this hearing that that seems to be where the focus of action is.

DR. NEWHOUSE: Where?

DR. BERENSON: At OMB. So I think that -- but it's consistent through many OMBs I understand, not that OMB. It seems to be an institutional position that has persisted through many administrations. So I think that is the right place.

Now having said that, the competitive pricing demo

is in the statute, with budget neutrality and we don't seem to have the ability even to shift from a high payment area to a, if we say pick two sites, one was a high payment area and one was a relatively low payment area, as long as we were overall budget neutral, could we do some shifting? General counsel interpretation seems to be no.

So that one I think is congressional, and we're trying to push back and really clarify that direction. So I think OMB is where the basic action is but some of the demos have specific language and law.

DR. KANG: The one other thing that I wanted to point out on this issue is let's say even if we could get OMB or CDL to adopt a looser definition for budget neutrality. There is a real fundamental structural problem of how we pay for the program is that we have two pools of money. We appropriate dollars for HCFA's administration and then we have the trust fund dollars for clinical care. And so you cannot invest in more administration for the purposes of actually saving trust fund dollars.

When you really think about what a managed care organization does, it actually takes 14, 15 percent off the

top for better coordinated care, et cetera, at the management side, on the administration side.

So that's a very structural problem, even if you have a looser definition of budget neutrality in terms of actually the two streams of funds. So if you really want to get your arms -- you actually have to merge both.

DR. BERENSON: Because we're now down to under 1 percent for administration in relationship to expenditures, trust fund outlays. And there's a lot we cannot do because of that. And so in other words, I think if, in fact -- well, enough said. That is a real issue.

DR. WILENSKY: Ted, and then Woody and Peter.

DR. LEWERS: Thank you. Bob and Jeff, clarify something for me, if you would, because I think maybe I might be confused. Bob, in your page two you talk about you're administering programs through third parties that you're oversight rather than proactive and working at a distant level, this is referring to payment.

Jeff, you were talking about developing national standards and pushing those down to your carriers. Can you make that stick in the way of quality?

One of the problems that we know is that you put out directives that are determined at a national level and them somebody down below ends up doing it in a little different manner. We've had discussions and communications about the glucose sticks. I mean you put out a great policy on glucose sticks. And then all of a sudden, somebody down below changes it and the same sort of pattern of abuse that was occurring in the prior system is now probably going to occur and we didn't attack the problem.

So I'm worried that because of what Bob is saying here under payment is going to restrict what you're trying to do in quality. Can you clear me up on that?

DR. KANG: Yes. Actually, Bob really was referring to payment and the carriers and FIs. I was actually in my presentation talking about the peer review organizations. Our contractual mechanisms with the peer review organizations were able to be more prescriptive in the fact we're creating a situation where we're competing those contracts and actually pulling contracts for non-performance. You're right, we are one, whenever this gets very complicated and you're one layer removed, things can go

wrong, but presumably, we can address that.

Part of this actually has to do I think from if we actually can set up from Baltimore or Washington the actual performance measurement system and the standards, I think things flow from that. Part of the difficulty really is we haven't standardized this stuff up front and our carriers and FIs have actually kind of grown up locally and now we're trying to impose nationalization standardization while the PRO program is more we're going from the nation down.

But the other issue though I want to put on the table is that this is a requirement for the PROs. You have to remember that second or third overhead I had which really talked to the requirements for the providers, PRO ought to in the long run for the providers, hospitals, nursing homes, be a mandatory requirement to collect data to then report those measures, to actually improve, to meet minimums and then improve.

Right now what I'm doing, the peer review program is essentially a voluntary profiling and giving them information and hope that it's going to improve. I think that we do need at some point conditions of participation

where, in fact, the providers themselves have to use this data and actually meet minimums and improve.

DR. LEWERS: Just a brief follow-up on that. I understand that you're dealing with the PROs and the contracting but you're also contracting on the other hand with your carriers. You don't have the authority in your contracting to hold them to certain standards as well?

DR. KANG: No, we do. It's just the way the whole program has developed, the tone and kind of the culture and everything is, and we're trying to do that also fiscal intermediary and FI and the carrier side. But the program really in many ways on the carrier and FI side started off just as local, people used the local Blues without a tremendous amount of national direction, we're now trying to turn that around.

DR. LEWERS: Thank you.

DR. KANG: But there's a tension also, I'm sure Dr. Wilensky will -- health care is local also so there is a tension. And actually large national managed care organizations experience the same thing. How much do you nationalize versus how much you keep -- so we're wrestling

with that balance.

DR. BERENSON: I would again point out, for those of us who come in new, sort of fresh-faced and think there's a better way to do things, a lot of centralizing to Baltimore, a lot of this decision-making, we don't have the resources to take on an awful lot more and there's a reason that we still defer a lot to the contractors, to the carriers and the intermediaries because of simply resources.

Then as Jeff points out a sense, certainly many of the provider community of having a local presence rather than a national government presence so that there's more responsiveness. Now in recent years there have been -- it used to be that my carrier was in my state and it might have been the medical director I might have practiced with. Now we have a number of the carriers and intermediaries are somewhere else. And so I think we're losing some of that local culture anyway.

So I think we need to be talking about, then retalking about this issue of centralized decision making versus decentralized in the contract. There's also limits on who we can have as contractors and intermediaries. We

can't just competitively bid for any organization that we wish to come in.

DR. MYERS: Can you speak, both of you, to the issue of the current state of your data systems? Now that MDS has been buried, I believe, is there a successor in mind? Do you have access to the data in a timely fashion that you need it?

The second issue, talk to us about public reporting of the provider specific quality efforts that you're involved with because they're a part of the PRO organizations. Does that keep them from being publicly available or are they subject to FOIA? And what are you doing with respect to that issue and do you believe it's an appropriate use of the data?

DR. KANG: On the first issue, first of all, we do have to remediate Y2K, and that's a big process but it's interesting in my group that we have a clinical information system which I think is the wave of the future. It's relational database. We actually are already Y2K compliant. The view that I've been pushing is this notion of actually making software available free on the Internet for the

collection of all sorts of data. In doing so you end up with, by definition, a standardized report, the data dictionaries associated, standardized reporting coming into us.

And then what the federal government needs to do is standardize the data elements, the data definitions or specifications and then the software collection tools, make them available publicly. And then the reality is, is the information derived thereof?

That's what people want a proprietary but that's also what the added value is. It's taking the information derived from that, that's standardized that we can all share and then actually making decisions.

My best analogy of this is accounting. There's a FASB board to create accounting standards so that all balance sheets are the same. But then every accounting firm will do it a little differently for each company or whatever for the purposes of internal issues and that's the added value. The added value is not having a proprietary kind of collection tool. We're heavily moving in that direction. And my group is Y2K compliant and this HAVEN and RAVEN stuff

is actually coming from my group.

DR. BERENSON: I was just going to say, this does get confused even on the Hill of all places. The Y2K problem we're having mostly relates to our contractors on the fee-for-service side, the shared systems and FIs and the contractors and we're completely dependent on their ability to be Y2K compliant. The managed care data system is internal. It's being upgraded right now and we have work plans to have an integrated managed care system but it will be Y2K compliant, it's within our control. There's no plans for anything like MDS.

I think the Office of Information Systems is looking at new architecture that a number of components to plug into but I think there are no plans like MDS. The managed care data system, there are a couple of interactions with the fee-for-service. The encounter data that's being provided to permit us to do risk adjustment, we need the FIs to receive it and to send it back to us and we need the common working file for storing the enrollment data that we get from SSI. That we think is in pretty good shape in terms of Y2K. But the basic point is that they're

completely separate, the managed care data and the fee-for-service data at this time.

DR. KANG: I have to say, we actually make our claims data at least on the Part A side available through what's called the SDPS system. This is through the PROs. All 50 PROs actually have access to this data and it's in a relational database. It's very accessible so once we make that conversion from the common working file to our systems it works quite well. I think what's happening at least in that clinical information systems is maybe the wave for the future.

We'll have to see but we're starting around clinical information. Your second question was the issue of?

DR. MYERS: Public reporting.

DR. KANG: Yes. To the extent that's being done in the peer review organizations, it's actually not available for public reporting. The statute's quite clear it is for internal quality improvement. I think then what we would do is at some point when we feel comfortable, the provider community and et cetera, the scientists and the

experts, we would say now, no longer report to the PROs, now report to HCFA. At that point, then we are prepared, we will take in advance that we're prepared to do provider profiles out to the community through HCFA. But it is done in the context of the peer review organizations. It's actually --

DR. MYERS: So right now all of your provider specific analyses are done under the context of PRO, therefore, not subject to FOIA?

DR. KANG: That's correct. All may be stretching it a little bit, but most. I'd have to go through the list, but we use that deliberately. I mean to the extent that we don't think we're prepared, we want to do it in the context of the PROs, then when we think we're ready for public reporting, we move it out of the PROs to HCFA. We deliberately do that.

DR. KEMPER: Jeff, I had two questions that I didn't understand about your presentation with the PRO quality improvement priorities. I didn't understand how this gets translated into better quality if it isn't a provider profiling kind of system with some feedback to the

providers. Is that how it works?

DR. KANG: Yes, I'm sorry. My expectation is it will be provided. The CCP data I showed you was all hospitals and they each had a profile and I apologize. I should have brought a slide there on that. What I was wrestling with though was the question of how is HCFA going to hold the PROs or contractors accountable. We intend to hold them accountable for their state. So we're creating a measurement system which looks at their state performance because that's their unit of contract.

My expectation though is that when they want to hold, they think about how am I going to improve the care in my state, they're going to in turn say, I need to actually drill down to the provider-specific level so I can actually go to the provider and say you've got to improve. But it's not mandatory. Maybe that's -- I suspect though what we've learned from quality improvement, and John Eisenberg talks about this a lot, is provider profiling and feedback is pretty critically for the provider group.

But from a contracting standpoint with the PROs we're going to put them on the hook for state-based

improvement. How they really do that is -- but I suspect they will end up doing provider profiling.

DR. KEMPER: So essentially the price for delegating this to the PROs is that you only monitor at the state level.

DR. KANG: That's correct.

DR. KEMPER: And it will be left to them to -- okay, I understand. The other thing was in your quality performance measure initiatives. I didn't understand what you were proposing on the population based surveys and what that was and how it might be used?

DR. KANG: You'll have to help me. The population based -- are you talking about the satisfaction surveys?

DR. KEMPER: The BRFSS type instrument.

DR. KANG: That actually is, for all of those who are familiar with BRFSS it's run by the CDC and that really is a state-based unit of analysis and it's primarily around risk assessment. What we hope to do is add a Medicare module to that to get Medicare questions about behavior at the state level. So we could, for example, get flu vaccine rates at the state level for Medicare beneficiaries.

So again, this would be primarily for a state based monitoring system against which we could monitor PRO performance.

DR. KEMPER: And is that fee-for-service only?

DR. KANG: That would actually be for fee-for-service and managed care.

DR. KEMPER: But not broken down that way?

DR. KANG: We are actually talking about a stratified sample where we could break it down by managed care and fee-for-service. And yes, it would be a matter of asking the question in the survey, who's your payor or getting it out of our files.

It's an interesting question which we're wrestling with is we are really interested at HCFA as the improvement of the entire population, irrespective of managed care and fee-for-service, from a policy, kind of from a programmatic standpoint do we wish to attribute differences to managed care or fee-for-service? I think we should do that in the long run.

I'm actually wrestling with some short term real life exigencies where I may choose to just combine the two

on the first iteration but in the second iteration be able to get finer detail. It's just more of a real operational issue.

DR. KEMPER: So this would not be information for consumers at any point?

DR. KANG: To the extent that it's state-based, we would be happy to release state-based information. I'm not sure what consumers do with state-based information though. They say, maybe I ought to then move to, you know, whatever, and that's somewhat of a problem. But we certainly would make it available.

MS. ROSENBLATT: The material that you presented -- and thank you both very much for taking the time -- made a distinction between managed care versus fee-for-service. I'm assuming that PPO would fall within the managed care definition and the health insurance industry is very interested in quality. But I know that there has been some concern about applying the same quality initiatives to PPO as well as HMO. Could you comment on that?

DR. KANG: I think from a measurement perspective actually, in terms of the clinical measures, particularly in

HEDIS, the PPOs, if anything, have an easier time getting the information because PPOs traditionally have all the claims data.

So when you think about HEDIS mammography rates or diabetic eye exams or something like that, they actually have an easier time of getting the information. The question though is can PPOs, because it's somewhat of a looser network, actually improve performance and it really depends.

I think the very early PPOs which were essentially just discounted fee for service and kind of without a whole lot of contractual requirements and whatever, are going to have a hard time. But I think there are other PPOs which have been able to show, in fact, the ability to use this data, feed it back to providers, working on performance improvement.

So I guess the answer depends on which PPOs you're talking about. But I would agree that there are some PPOs which are going to have a hard time. Not on the data collection side but would actually on performance improvement side.

DR. BERENSON: I guess my comments would be two. And both Jeff and I have met with representatives of PPOs who expresses these concerns. I think PPOs have much less ability to deal with out of network care and there is much more out of network care in a PPO than in a tight HMO but HMOs with a point-of-service are moving more towards the PPO. I think PPOs, if they are a very large network with a significant percentage of the physicians and hospitals in the community may have more difficulty focusing.

I mean if quality improvement is focused on moving the mean, maybe they have more ability to deal with outliers or unacceptable behavior. And I think we've said that the kind of quality improvement projects that a PPO might want to initially entertain might be somewhat different.

Now the organization itself has some ability in some of the quality areas to deal directly with beneficiaries such as getting immunizations so some of their quality improvement projects might be beneficiary oriented. We've said that we think that any organization can do quality improvement, the specific nature of the project might be somewhat different and we would entertain a PPO

that wanted to do something that was more consistent with a PPO culture, that would be fine.

On the issue of, as a couple people have said, our numbers may not look as good, well, that's the choice that beneficiaries get to make. They're obviously in a PPO, they have more easier access to a broader network and they will have the information on performance and make a decision as to whether that should be a determining factor or some noise that they wish to ignore.

But the concept of providing standardized information for choice, the law says and we believe should apply to all of these organizations and let the beneficiaries then make the decision as to what the implications of that information is.

DR. KANG: The only other thing I just wanted to mention, and this is kind of -- you may have heard about an effort in California called CCHRI or California Cooperative Health Reporting Initiative. What were beginning to happen and to accept that PPOs are players, is that you have five or six different plans, contracting with the same whatever, five or six different physician groups, if you end up with a

centralized data collection point infrastructure, you can either end up with plan accountability or use that same information to look at group practice accountability.

I believe that the PROs can offer that infrastructure and then the reality is PPOs can play in that game and then go along with the HMOs and whatever, and go to the practice and say, look, guys, at your performance. So I'm trying to create an infrastructure that would allow PPOs to also play in that game, get provider specific reports out that they could, with other insurers or purchasers go to the providers and push them on performance improvement.

DR. BERENSON: I guess having spent 10 years helping run a PPO, I mean I guess we could do anything except shift risk. We took credentialing very seriously, selective contracting, we actually had a product which involved a gatekeeper product within a PPO, a non-risk bearing PPO. We did a number of things that I think HMOs can do.

Obviously, if it's a statewide PPO, with most of the doctors it's going to be different. But there's nothing inherently about the structure of a PPO other than the

inability to shift risk which prohibits a PPO from doing credential -- I mean again, in a meeting we had, PPO didn't want to do credentialing because it's clients who -- I mean it was basically in an ASO situation and the employers who were contracting with it didn't want them to do contracting.

But there's nothing inherent in a PPO structure that doesn't permit it to do what our QISMC requirements would have a PPO do. Again, we want to be very sensitive to start up times and permit some transition. But PPOs, the BBA calls them a coordinated care plan and so we have consistent standards for coordinated care plans.

MR. SHEA: As important and challenging as the quality improvement initiatives are, it seems like that area of activity that focuses on educating and enabling beneficiaries for making choice and being decision-makers, and people that were able to search and secure quality is an even much more daunting task for Medicare. We've heard from various people about what's been done in private groups and yet Medicare is the ultimate non-group.

And on top of that we've seen how little money was appropriated for this. I'd be interested in your comments

on what you think could be done in the short term or maybe over time to improve your ability to work in that area.

DR. BERENSON: Happily, Carol is in charge of that. One of the -- I mean there's been a lot of controversy about the reorganization of HCFA, whether it made sense or didn't make sense, but one of the things that I think made sense is having a specific organizational unit, the Center for Beneficiary Services who has as its main job communication and education of beneficiaries.

Apparently, they're putting together, and Carol Cronin is the new head of that, and we've started talking about how do you communicate to beneficiaries about quality, about the need to not assume that simply because somebody has a license that they're providing the same level of quality as somebody else. They actually have a PBS series in mind that's related to educating beneficiaries and I think we need to put quality on that agenda.

I think this is a long term. I don't see anything short term. My hunch is that we're committed this year to putting HEDIS data up on the Internet and then handbooks in the five state demo. And I'm sure that most beneficiaries

won't know what it means and will want to stay with their doctor.

But I remember 20 years ago or so when food labeling requirements came in, Loretta Lynn was on TV holding up Crisco and saying that it has no cholesterol and I'm saying the public doesn't even understand that saturated fats will kill you and the fact that it has no cholesterol isn't terrific.

Well, I don't think she could get away with saying that today. I think there has been a huge shift in how it's presented, the education of people, about what it means, and we will start with measures that most people sort of scratch their heads and say well, that's not what I need. And in 10 or 15 years we'll look back and see this was just where we started.

So I very much think this is a long-term project to educate beneficiaries about quality and that's what we're embarking upon. I don't see any short-term fixes.

DR. KANG: I think Carol has resource issues. I just see from my perspective, as kind of the person who's responsible for getting her information, I think the biggest

barrier from my side is the information systems and the standardization or lack thereof. As you know, you go look at a doctor's medical record, you can't even read it. So there are a whole slew of issues here.

But I think it's important that we do this, the market demands it. It's going to take some time.

DR. WILENSKY: Thank you. You've been very generous with your time and very forthcoming with your --

DR. BERENSON: I have an answer for Jack, but he's not even here.

For the record, the demonstration -- actually, this is the provider partnership demo, the organization actually proposes a discount to HCFA. It's more like a market. And HCFA negotiates the discount and they tend to be on the order of 3 to 4 percent.

DR. WILENSKY: We'll tell him. Thank you very much.

Beth, do you want to come and make sense out of all of this, of where we go as a Commission on these issues.

MS. DOCTEUR: I was going to turn to you. This final session really was set up to give you an opportunity

to provide staff with some feedback and direction in terms of your interests and the future work that you'd like to see in the very broad area of quality and this Commission's work in quality over the coming year and beyond.

I put together a staff paper, an extensive staff paper that I'm not going to review here. The primary purpose of the paper was to provide a little context for some of the expert panels that we've heard today, and also to try to raise some issues that I think this commission could fruitfully try to address in some of its work this year. So I'm sure that the panel stimulated many thoughts and I'm interested in hearing those from you.

What I am going to do is just take a few minutes to refresh your memory on some of the proposed projects that are discussed in the paper, general areas in which the commission might want to focus and some of the issues that this commission might want to address. So let me review those.

The first project that the commission might want to consider undertaking this year would be an analysis of some of the quality improvement and assurance systems that

were set up in Medicare both for the fee-for-service and managed care programs, particularly the new program under Medicare+Choice that you've heard much about today.

As Dr. Berenson and Dr. Kang described, and as you know, both of the programs are in the midst of some extensive change and fundamental changes right now. This provides MedPAC with a nice opportunity to look at how those changes are being implemented, to identify some key areas in which the program has moved forward, and to comment on those changes and to identify some limitations.

DR. WILENSKY: Could I just ask you a clarification? Is the project under the Medicare+Choice, is that the QISMC?

MS. DOCTEUR: Yes, that is QISMC.

The purpose of this analysis would be to look at both the programs separately first and to identify the key changes, to comment on those changes where you had positions, and to look at some of the key issues that we've discussed somewhat in the past. Issues like how to set up a system that not only sanctions poor performance but also to introduce some rewards for exceptional performance; how to

fairly set minimum performance standards for health plans that don't unnecessarily discourage competition but do provide some level of the baseline protection from outliers.

On the fee-for-service side, there's been some discussion of some of the issues of how to create a greater sense of accountability. Also, how to influence quality of care under a system that really lacks care management levers.

So these would be some of the kinds of issues you might want to look at in these analyses. I think you might want to go a little further and take a step back and do some comparisons of the two systems to look at the ways in which those two systems are complimentary, the ways in which the two systems interact and overlap, and to question whether there's comparable attention being applied on both sides.

In terms of the policy significance of this particular project, I think that the timing is very good. Right now there's a lot of changes underway and this commission could weigh in on some key implementation issues. I think the timing would be good for this particular analysis and conceivably this could provide the basis for a

chapter in your June report.

Let me move on to the second proposed project or optional project for you to consider. This project would be to look at how Medicare policies might be revised to consider health care quality or other dimensions of performance in making payments to plans or providers. I think obviously there are a large number of important obstacles to implementing this type of payment system in Medicare, and you all know what those are, ranging from limitations to the data, problems with the lack of case-mix adjusters, limitations in the comprehensiveness of the quality measures themselves.

However, as we've heard today, and as we know, there are rapid advancements being made on all these fronts and it might be interesting for this commission to try to take some initial steps in thinking about whether there is the potential to proceed in this direction in the future with an eye to having this be a longer term project that probably wouldn't end up with any specific recommendations for specific approaches this year. But there is a work plan laid out in the paper. I won't go into it in greater detail

here.

Again, I think there is a lot of policy interest right now in approaches for enhancing accountability and also for establishing incentives for quality improvement. So this is another project that I think there would be considerable outside interest in, although to my knowledge -- as far as I know right now -- there's no specific initiative underway to try to really think about how to change payment policy fundamentally right now.

A third kind of general project area for you to think about is to look at how best to promote informed consumer decisionmaking, particularly under Medicare+Choice. The goal of this analysis would be to yield recommendations on the design of HCFA's consumer information program and on some of the other steps that might be needed to promote informed beneficiary choice.

I think this is another very large kind of area that you could get involved in as far as you wanted to go with this. I considered putting in another expert panel today on consumer information issues, but I thought you might be waterlogged at this point.

If you are interested in pursuing this, there's a lot of work that's being done right now and there's a lot of interesting things that you might want to hear about and weigh in on. There's extensive, or growing I should say, literature in this area and it might be interesting to kind of look and see what lessons we can draw from that from Medicare.

Let me move to the fourth project. The fourth proposed project that is outlined in the staff paper is an evaluation of Medicare program protections for beneficiaries. As you know, Medicare features a variety of structures, processes and standards that are designed to provide individual protections, both for beneficiaries as consumers and for them as patients.

This proposed project would review existing protections, particularly the changes made under the BBA and the Medicare+Choice regulations and compare those standards to not only bills of rights and endorsed standards that have been put forward by various groups, but also look for data on what's the norm for commercial plans, employer-sponsored plans, and other public programs to do some comparisons

there, and also look for data by which to assess how well existing protections do what they set out to do.

That would be one approach, with the idea of the commission trying to see if it was possible to arrive at some recommendations for areas in which perhaps protections need to be strengthened. Perhaps there are certain protections that you might believe have become obsolete. Perhaps there are areas in which additional protections might be advised.

I didn't mention in the paper, although I think I will mention now, that an alternative approach to take if you're interested in consumer protections but don't want to take the kind of comprehensive approach would be to pick a particular area of protection, perhaps confidentiality privacy issues are currently of great policy interest, and to focus in on one specific area and do it that way as opposed to the bigger approach.

Finally, the fifth proposed area for work would be to assess alternatives for instituting an error reporting system in Medicare. As we've heard today and know, the issues of how best to deal with errors in the delivery of

health care and to reduce the frequency of those problems is the subject of considerable current interest.

The president's quality commission recommended the development and adoption of a national error reporting system. Also, as you know, JCAHO has instituted a sentinel events program and is trying to get that up nationally for accredited organizations.

This approach would be to take a look and see whether there's a role for Medicare to play in developing or implementing such a system, whether it's advisable to look at other industries where such a system has been set up, notably the aviation industry, and to consider such issues as the implications from a standpoint of the medical liability system, also to think about the issue of state-based confidentiality and privacy laws and the implications here.

So we obviously have much more work here than we could conceivably do this year. So what staff would appreciate hearing from you is are there any of these projects that particularly interest you? Are there others that particularly don't? Are there other areas of interest

that you have that you'd like to see staff pursue? And are there specific issues within these kind of broad projects that you'd like to make sure are on the table for any future work? Thanks.

DR. ROSS: Can I have first on this? Because I just wanted to amplify for a moment that last point. This is a topic that potentially is as large and as wide-ranging as you want to get, and it could absorb as much staff resources as we want to put into it.

So the more clear direction you could provide, the better to help us focus on getting this.

DR. NEWHOUSE: Is there some issue about where the budget constraint is? Are we supposed to focus on one of these?

DR. ROSS: No, we'll attempt to do some sort of triage, but I think we can cover all the pieces. It's a question of how much depth you go into on each piece.

DR. CURRERI: As I read your report, I read it with this idea that you couldn't do all of these things. So for what it's worth, these were the two that I thought were the most noteworthy. Your number three was, I think, the

most important, that is promoting informed consumer choice. Not only is there a lot of action in this area, but if you really think about it, this is the bottom line. This is what we really want to do, is have consumers be able to affect the marketplace by making intelligent choices.

The second one that kind of intrigued me was your second one, because I've always -- in a rather cynical way, thought that the health system is largely run by what goes into the pocketbook. I'm interested to see whether -- there's two possibilities. Will all the curtailing, in terms of growth of the program that could result in a decrease in quality, and I think it would be interesting to set up some models and maybe even have some focus groups to see whether they would respond and how much it would take to have health systems respond to an incentive for quality.

I'm not sure they would. And if they would, I'm not sure how much it would take. I think it would be an interesting area to look at. So those were my two votes.

DR. MYERS: I love all of your issues quite a bit, but I know we can't do them all. The one that you didn't say a lot about was health information systems. Your last

point about it being the weak link is absolutely correct.

We tend to avoid discussing failure; i.e., MTS and the causes and so on, but it seems to me that that's a very important, to learn the lessons and then learn from that where we should be going in the future and the value, and link that to the errors question that you've raised.

Without an outstanding information system to really get at that errors issue, it's going to be very, very difficult. So that would be the A-number-one that I would suggest.

Another one that's very, very important that you talked about was the whole issue of confidentiality and privacy. But I'm not sure, and I would leave it to my fellow commissioners to comment as well, but that one really is now certainly the province of HHS. There's legislation that's been proposed, will be proposed, it will be a big topic next year. What would we add to that debate at this point becomes the question. And would our input be timely in a way that would allow it to be considered as part of what will clearly be a continuing discussion and a high priority discussion of the early part of the next year, if

not the rest of this year.

So I'd put a question mark behind that one, not in terms of its importance, but rather in terms of the time and effort that we should spend as MedPAC on it.

DR. KEMPER: First I want to say I thought this was a really useful paper. It really helped me begin to get my arms around something that's very difficult, I think.

I think of this in terms of which of these activities might the biggest effect soonest. Some of them are very long run in terms of their benefits and some of them might be a little shorter run. That leads me to favor two of these. One really only has three lines in here, and that is the focus on Medicare quality improvement in the traditional Medicare, because that's going to affect an awful lot of beneficiaries quickly, since that's where most of the care is.

It seems to me that that really isn't just one study but it's half a dozen or eight studies. There's RAVEN and there's HAVEN we learned today, and there are a whole lot of subsystems or activities there that it seems to me would be very useful to try to focus in on.

The second one is really not in your list but it is earlier on page 23, you talked about the traditional Medicare acting like a PPO. And when you listen to Bob Berenson talk about what could a PPO do to have quality improvement, there are things. You can't limit providers. You're not going to restrict networks, and there's an issue of credentialings, a whole different ball game. But just to think through what things might be borrowed from the PPO model that could be implemented -- or other models still within a fee-for-service system might be useful.

It might not go very far, but at least some thinking about that.

MR. SHEA: I thought this paper provided a nice complement to a good series of presentations this afternoon, so Beth, thank you. I had two general preferences, I guess I'd call them, and then a couple of specific comments.

The two preferences are, like Bill I think the consumer work is very important here and those projects related to both decisionmaking and consumer protection I would strongly endorse. And I also think, witness the last presentation, the orientation -- HCFA is not going to have a

consumer information, decisionmaking orientation. I think they're going to have to push there, in part, I think because that's not their history and they haven't been given the resources on it. But I think it's going to take our support, should I say, to get them there.

The other preference would be against, at this point, tackling the issue of payment related to quality. I think it's a very important issue and would be very useful. I would suggest it might be the kind of thing that could be not this year. I say that just because it's sort of a traditional approach for us to take, I think, in this. Let's look at the money end of this business.

And I really think what's needed now on this whole area is emphasis on the other parts of this quality equation, not so much the money. I think there is a lot of work that could be done in that area, but I'm afraid if we got down there we'd spend all of our time doing that.

And then, just a couple of specific comments. I like the idea of the panel on consumer information decisionmaking. And under the review of the Medicare quality improvement programs, if we did that, I would hope

that one perspective that we bring to that -- or the staff could bring to that study -- is let's test what Medicare is now doing against what NCQA, FACCT, to a less extent JCAHO, think they have to offer Medicare. Are they taking full advantage of the tools that are being developed by the people we're talking about?

And then lastly, I don't know whether it's a this year project or not, but I think the errors reporting system is a very important national discussion that we ought to be in at some point. Whether it's this year or next year, I don't know.

DR. NEWHOUSE: I was a little like Woody and liked them all. But I wanted to ask about the error reporting system. I'm investing some of my own time and trying to do something about errors. Chuck Buck, I noticed, brought it up in his talk.

My question for you is, since I never really thought about this specifically in the context of Medicare, was what you had in mind. The couple of sentences that were there seem to envision something that was Medicare specific.

MS. DOCTEUR: My first take on it, in thinking

about it, because I was obviously looking for a Medicare angle in an issue that I thought was worthy of this commission's attention. I thought perhaps there's a way --

DR. NEWHOUSE: We do know that there's a disproportionate number of errors among the elderly.

MS. DOCTEUR: Exactly, a lot of the errors, for many reasons both due to the hospitalization rate and there's certain areas in which errors have been studied because of Medicare data, and we know about errors in the Medicare population.

That was my initial thinking, maybe there's a way that Medicare could set up a standard and then the industry would follow. But after looking at it in a little bit more depth -- I still haven't looked at it in great depth -- but seeing what JCAHO has been trying to do and the concerns there are particularly about the question of the differences in state-based confidentiality requirements, and that's posing problems for having a national system.

It's not clear whether if you thought an error reporting system, after looking at it, was the right way to go, it's not clear whether the best way to address that is

to have a national law that pre-empts the state confidentiality rules in certain ways, or whether it's best to maybe endorse the state-based model. In that case, the only conceivable Medicare angle would be to do something through the PROs, I would think.

DR. WILENSKY: Gerry, I wasn't sure, when you made your comment about not wanting to do the prices or the payment, I actually agree with you but for a different reason, but I wanted to be sure you understood that what is being proposed is that, to the extent that we can identify improved quality, to increase the payment to reward through improved pricing for better quality so that rather than have a uniform price, you pay more for better quality. That has been talked about by the Labor Committee and by some of the other committees.

I actually, although I'm in intrigued with the idea, would think it is not particularly worth our while because I think the politics of that are so remote that we can afford to let the private sector develop it. If it becomes absolutely accepted behavior in the private sector, maybe the public sector would consider it, but I'm not even

sure then. I think the politics of doing that are so remote that it's not really so much worth our time as opposed to whether it's a good idea.

But what I do think would seem to me areas that are very important for us are the two that have been mentioned; the quality with regard to fee-for-service because it's the harder problem and it's because where the bodies are. And the second is the consumer information. I think as Bill Curreri said, ultimately that's the bottom line.

MR. SHEA: I think short term, there's a lot of quality improvement measurement issues that people are working on. You can clearly see how you could make advances over a period of time, not just to Medicare but generally. There's a lot of work to be done, it's difficult, it might be very expensive, there are information issues.

I think longer term the real payoff here is if you could actually operationalize this notion that consumers could get information which they could evaluate in some balanced way and make decisions, and therefore promote it. I think the FACCT people comes closest to having a vision

that seems to have a lot of power.

What I am cautious about, or I am cautioning us about is, looking at this in a traditional way, which is to say could we use payment policy to produce a certain outcome? I think that would be sort of the traditional approach here. Let's do this and we'll test that out for a few years. I don't think that's where the real importance is.

MR. MacBAIN: Just a little variation on the consumer information piece, I don't know if this is a little beyond our normal scope, but the other question, in addition to what you report and what sort of information you gather, is how do you report it? How do you put it in front of people in a way that's meaningful? Whether it's the number of stars, like a movie rating, or the little circles like Consumer Reports uses.

And to get back to my earlier point with the first panel, how do you report that kind of single point data with some sense of variation as well, so that you have a notion of not only here are the plans that fell above the national average or the regional average, but among these here are

the ones where you've got the greatest likelihood of actually getting good care from any randomly chosen physician or hospital within the plan.

I think we're a long way from that, from the kinds of reporting that comes out now. It's pretty technical stuff and not real appealing.

DR. CURRERI: But I think that, Bill, California has a lot of experience in presenting consumer data. We, in the past, PPRC were given a fair number and some of them I thought were pretty unique. They were all visual and you can't explain standard error, I don't think, to the consumer.

MR. MacBAIN: No, you can't.

DR. CURRERI: So you have to have some visual way of getting the same thing.

MR. MacBAIN: That's what I'm looking for, is examples like that and even examples from other industries of how you report that sort of data.

MS. ROSENBLATT: I just want to say, I found today to be an excellent meeting. Having all these experts there and listening to different perspectives was terrific. So if

you were the organizer, thank you for organizing that.

I was also very moved by Dr. Lynn's comments this morning and about how little data there is on a very, very important subject. I would vote for something that I don't think is on the list, it may kind of be implied by your list.

I would vote for doing something that is moving towards that, that end-of-life and quality at the end-of-life thing. It just sounds like there's a desert there and any movement in that direction, and anything we could do to take one small step in that direction would be helpful.

MS. DOCTEUR: Let me just comment that there is actually a separate agenda being developed by staff on the quality of care at the end of life issues, and it's a high priority right now.

DR. LONG: Just following on, I would just comment that especially on the point that Jack made earlier to remind ourselves that we are dealing with the Medicare population and that's a very special population that is not the general consumer. It's not the employee/employer market. Some of them are their own decision-makers. Some

of their families are the decision-makers. Some of their providers are the decision-makers. The unit supervisor in the nursing home is the decision-maker.

There are lots of decision-makers out there who have different capacities to absorb information, and are making different ranges of decisions. It's a very complex population, including those that are taking longer to die, who have diminished capability. And in the same sense that we may need to be able to have a series of indicators that tell us when we move into a different mode of care, we may also need a series of indicators that tell us when we move into a different form of information and decision-making.

DR. WILENSKY: Any other comments?

You'll have to come back and tell us whether we've given you enough guidance.

MS. DOCTEUR: That was great. Thank you very much

DR. WILENSKY: Thank you.

We're going to open this to public comment, if any would like to add anything to the discussion.

MR. DIAMOND: Thank you, I'm going to be real brief because I know you want to get home as well as I want

to get home. I do live in Washington D.C. I'm Lou Diamond. I'm the president of the End Stage Renal Disease Forum of networks, which are the PRO programs, if you will, of the end stage renal disease program. As a matter of disclosure, in my other life, the one that my wife concentrates more on, I am the medical director of the MedStat Group, which is a health information company.

I just wanted to spend a moment of time with you today just sharing with you the quality agenda that the end stage renal disease program is pursuing in partnership with HCFA. The hand-out describes it in pictorial form. I'm not going to go through those details with you this evening except to say that what we've attempted to do is reframe our agenda based on the recommendations of the presidential commission, and it's built on attempting to establish a national infrastructure, health information infrastructure, a commitment evidenced by its medicine and the measurement system, patient participation at the various levels that you've been discussing, and local implementation and quality improvement.

My real purpose for speaking with you briefly this

afternoon is to suggest to you -- maybe not urge to you, given the long agenda items that your staff has shared with you -- that it might be appropriate for you to focus on some study of this particular program, given its uniqueness, and given some of the successes that it is achieving in implementing a quality agenda, and given some of the challenges that it is facing. That's the message that I'd like to leave with you.

Thank you.

DR. WILENSKY: Thank you. We had, last year, indicated that we wanted to spend a little more staff time on this issue than we were able to do last year. So we'll certainly take this into consideration.

MR. DIAMOND: Thank you.

DR. WILENSKY: Thank you very much.

MS. MERCURE: I promise not to take long. Employers are already beginning to experience, because they're starting their open enrollment, the dislocation where some of the plans are beginning to retreat from some markets. I would just suggest that you look at that. That is something that private sector purchasers I'm sure would

be willing to help you with, and even do some dislocation analysis of what that means. I think that's very important to what's happening with Medicare+Choice in particular.

Thank you.

DR. NEWHOUSE: I didn't understand that. Can you elaborate?

MS. MERCURE: Sure.

DR. NEWHOUSE: I understand their withdrawal. But how is that linking to the employer?

MS. MERCURE: Because what it means for that employer is, they've gone out with what plans that retiree can elect. Suddenly, that plan isn't available in a market area, and that employer is going to be deluged with calls. I already got a call from my parents when their plan -- so there's an issue of communication with this dislocation.

DR. CASEY: My name is Don Casey. I work with a PRO in Maryland and I'm the principal coordinator. I just want to share an experience that I had in the past six months and the stuff that Jeff Kang was talking to you about before. And that has to do with the realm of quality improvement projects at the provider level.

It seems as though we've had tremendous success getting buy-in costs in the state of Maryland with pneumonia projects that I think is going to be a prototype. And I think that the success of that really has been because we've been able to link the measurement to outcomes first, but also I think we've looked at this as an opportunity to bring back some added value to the providers that they heretofore had not been able to get their hands around. I'm talking in terms of resource allocation utilization.

Mortality is one thing. I think the cost benefit is the other opportunity. So I'd just throw that into the ring to keep in mind in terms of the way these indicators are structured. I think the closer you can get to melding that, the better off you'll be.

DR. WILENSKY: Thank you. Any other comments?

MR. BAKER: My name's Dale Baker. I'm a consultant. My office is in Indianapolis. My company is Baker Health Care Consulting. I work with hospitals in about 30 states, primarily in urban Medicare geographic reclassification and wage index matters, et cetera.

Once a year I go out and see my clients. It's the

most wonderful time. Drive around the country and ride airplanes around the country and hear what's on their minds. There's an issue that came up this year over and over again which I'd like to share with you that has some impact on quality and also payment on a short term basis, and that's really dealing with the Balanced Budget Act.

As I went around this year talking to my clients -- and I always learn much more from them than they ever learn from me -- there is great concern that the Balanced Budget Act may have gone too far in certain areas. I want to bring that to your attention. I think it's an important issue. And my evidence is totally anecdotal, but let me share with you a couple of the concerns and the couple of the things I've learned from some of my clients.

First of all, I think 13 months has passed since that was signed into law, I believe to the day, and we've certainly got a very different time than we had 13 months ago with a $1.5 trillion budget surplus in the next 10 years. Who would have believed that? So perhaps it is a time to think about that.

But some of the concerns I heard are, first of

all, home health. They think the home health provisions are very, very bad. In terms of a specific example, like the Integrated Health System in Zanesville, Ohio has just cut back their home health services from 23 counties in that part of Ohio to six counties because the payment rates have been sliced so badly.

Another area of concern is the SNF payment rates. I've had several clients tell me that this had not filtered its way through the industry yet, but it's really got some very bad potential implications to it. A hospital, Monongahela Hospital in Morgantown, West Virginia as of July 1st, the first day of their new fiscal year, they closed down the SNF unit because the payment was equal to about their marginal cost of operation. So they simply couldn't keep it open.

Another area that's of great concern to my clients that I would like to just again bring to your attention is the whole issue of transfers and the decrease in payment and the disincentive for health systems to provide post-acute care services to patients once they're transferred from a hospital. There's a very strong disincentive for providing

those services within three days, which I think is questionable public policy in the first place.

The second thing is, if as a result of some of the changes in closure of SNF units and some of these things, hospital length of stay increases, which will actually increase payment under these transfer provisions, these hospitals are setting themselves up for fraud and abuse charges to be made against them simply because of increases in the length of stay that may be resulting from some of the other changes in their operations resulting from the Balanced Budget Act. The last one I'll just mention to you is some of the therapy units, et cetera.

But over and over, from my clients, this is the anecdotal issues that came back to me, in a period of time of real change in the last 13 months. I just want to bring that to your attention as an area that you may want to take another look at. It's an area that perhaps some more fine-tuning of what was done in 1997 in the Balanced Budget Act might be appropriate in the short term, without the kind of data that you as a commission are used to seeing.

I'd also like to congratulate you just for what

you do. You do a great job.

DR. WILENSKY: We'll be doing the discussion of post-acute tomorrow, both SNF and home care.

Any other comments?

It has been a very productive, but lengthy, day. Commissioners, we will reconvene at 6:30. Again, let me remind you, we'll have an executive session from 8:30 to 9:00 in the morning and then go into public session at 9:00 in the morning. Thank you.

[Whereupon, at 5:30 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, September 18, 1998.]